West Yorkshire & Harrogate Cancer Alliance

Head and Neck Cancer Treatment Guidelines

Updated July 2017

Version 5.0

i Document Control

Title	Head and Neck Cancer Treatment Guidelines
Author(s)	West Yorkshire & Harrogate Cancer Alliance Head & Neck MDT Leads
Owner	West Yorkshire & Harrogate Cancer Alliance (WY&H CA)

Version Control		
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2.2	21/12/2011	Addition of Pharyngolaryngectomy pathway
2.3	01/03/2012	Updated Calderdale table in Palliative Care and End of Life Guidelines
2.4	15/03/2012	Additional piece on HPV status in oropharyngeal cancer
3.0	December 2013	Full review of guidelines
4.0	August 2014	Full review of guidelines and revised Palliative Care section
	May 2016	Publication of Head and Neck Cancer: United Kingdom National Multidisciplinary Guidelines (open access)
5.0	July 2017	Full review and update

Contributors to current version		
Contributor	**Author/Editor**	**Section/Contribution**
Head and Neck NSSG members	Head and Neck NSSG	General amendments & Pharyngolaryngectomy pathway
YCN Sub Regional End of Life Care Group	Head and Neck NSSG	Palliative care chapter
T K Ong and MDT colleagues		Review and update

ii Information Reader Box

Title	Head and Neck Cancer Treatment Guidelines
Author(s)	West Yorkshire & Harrogate Cancer Alliance Head & Neck MDT Leads
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Contact details	West Yorkshire & Harrogate Cancer Alliance NHS Wakefield CCG White Rose House West Parade Wakefield WF1 1LT

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1 Introduction

1.1 National Guidance for Head & Neck Cancer

The NICE 'Guidance on Cancer Services - Improving Outcomes in Head & Neck Cancers - The Manual 2004 , lists the following key recommendations:

- Services for patients with head and neck cancers should be commissioned at the Cancer Network level. Over the next few years, assessment and treatment services should become increasingly concentrated in Cancer Centres serving populations of over a million patients.

- Multi-disciplinary teams (MDTs) with a wide range of specialists will be central to the service, each managing at least 100 new cases of upper aero digestive tract cancer per annum. They will be responsible for assessment, treatment planning and management of every patient. Specialised teams will deal with patients with thyroid cancer and with those with rare or particularly challenging conditions such as salivary gland and skull base tumours.

- Arrangements for referral at each stage of the patient's cancer journey should be streamlined. Diagnostic clinics should be established for patients with neck lumps.

- A wide range of support services should be provided. Clinical nurse specialists, speech and language therapists, dietitians and restorative dentists play crucial roles but a variety of other therapists are also required, from the pre-treatment assessment period until rehabilitation is complete.

- Co-ordinated local support teams should be established to provide long-term support and rehabilitation for patients in the community. These teams will work closely with every level of the service, from primary care teams to the specialist MDT.

- MDTs should take responsibility for ensuring that accurate and complete data on disease stage, management and outcomes are recorded. Information collection and audit are crucial to improving services and must be adequately supported.

- Research into the effectiveness of management – including assessment, treatment, delivery of services and rehabilitation – urgently requires development and expansion. Multi-centre clinical trials should be encouraged and supported.

Head and neck cancer, Quality Standard 3 March 2017, NICE guidance lists the following 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.

1.2 Purpose and Scope of these Guidelines

The purpose of this document is to set out agreed clinical guidelines for the investigation and management of Head & Neck Cancer which are based on NICE Improving Outcome Guidance for Head & Neck Cancers.

This document's original version had been produced by members of the former YCN Head and Neck Cancer Group. The group was made up from representatives from three multi-disciplinary teams (MDT), all specialising in head and neck cancer. It is aimed at summarising our clinical approach to managing patients with head and neck cancer.

Ultimately, our approach is always orientated around the individual patient. All our patients are discussed in the MDT meetings (MDT). We believe that by combining our knowledge and experience, we will offer the best advice for patients and families.

1.3 Publication of Head and Neck Cancer: United Kingdom National Multidisciplinary Guidelines (May 2016)

ENDORSED BY:
British Association of Endocrine and Thyroid Surgeons (BAETS)
British Association of Head and Neck Oncologists (BAHNO)
British Association of Oral and Maxillofacial Surgeons (BAOMS)
British Association of Otorhinolaryngology–Head and Neck Surgery (ENT UK)
British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS)
The Royal College of Pathologists (RCPath)
The Royal College of Radiologists (Faculty of Clinical Oncology) (RCR)

The management of head and neck cancer has already been the subject of extensive review by an expert multi-disciplinary team in 2016 and endorsed by the seven medical specialty organisations (listed above) involved in head and neck cancer care.

Our management may vary for a variety of reasons from the guidelines. However, we endorse and follow the guidelines – see link for open access below:-

https://www.jlo.co.uk/news/head-and-neck-cancer-united-kingdom-national-multidisciplinary-guidelines

This WY&H Cancer Alliance document also describes the roles of the local care teams and specialist teams including referral pathways.

These guidelines will be reviewed at least every three years or when new guidance is available.

1.4 Head & Neck Cancer Services in the WY&H CA

The West Yorkshire & Harrogate Cancer Alliance (WY&H CA) has a resident population of approximately 2.6 million and there are 11 Clinical Commissioning Groups and 6 Acute Hospital Trusts within the Network. The Cancer Centre is based at Leeds Teaching Hospitals NHS Trust

There are two specialist Head & Neck MDTs within the WY&H CA Network (3 including York) as shown in the table below. These MDTs are held weekly.

Hospital Trust	Specialist MDT Team
Bradford Teaching Hospitals NHS Foundation Trust Airedale NHS Foundation Trust Calderdale & Huddersfield NHS Foundation Trust	Bradford Head & Neck MDT St Luke's Hospital Bradford
Leeds Teaching Hospitals NHS Trust Mid Yorkshire Hospitals NHS Trust	Leeds & Mid Yorkshire Head & Neck MDT St James's Institute for Oncology Leeds
York Teaching Hospitals NHS Foundation Trust* Harrogate & District NHS Foundation Trust	York Head & Neck MDT York District Hospital

*Please note that York Teaching Hospitals NHS Foundation Trust is now part of the Humber Coast & Vale Cancer Alliance

1.5 Network Clinical Pathway

The former YCN Head & Neck Group had developed a Network clinical timed pathway for Head & Neck Cancers plus a Pharyngolaryngectomy pathway

A former YCN and HYCCN Teenage and Young Adult with Cancer Pathway (16-24 years) has also been developed for use across the region.

1.6 Evaluation and General Principles of Treatment

Head and neck cancer is not common and represents less than 5% of all cancers in the U.K. The Yorkshire network sees over 450 cases per year. It is more prevalent in poor socio-economic groups, with tobacco and alcohol consumption as major aetiological factors. Complexity is related to the number of anatomical sites, technical difficulties as regards the clinical staging, radiology, surgical ablation, surgical reconstruction, radiotherapy, the demands on the non-medical clinicians, the devastating impact of the cancer and it's treatment on the patient's quality of life as well as that of their carers. Traditionally there has always been recognition of the need for multi-specialty working in the management of patients in Yorkshire. Policy initiatives have resulted in formalisation and strengthening of established ties and the development of these medical guidelines.

The group consider it mandatory that all patients in Yorkshire with head and neck cancer should be reviewed/discussed in one of the MDT. There are three in the Network based at Leeds, Bradford and York. The flow of patients between referring cancer units to these MDT and the links between Bradford (include Huddersfield, Calderdale and Airedale), York (include Harrogate, Scarborough and Bridlington) and Leeds (include Mid Yorkshire) have been crystallised and are distilled by widespread consultation and assent into the following guidelines.

We believe in adhering to current best medical practice, based on evidence, national and international guidance as well as our collective MDT experience. The guidelines (see latest 2016 version - open access link on page 8) are intended to act as a framework and are not intended to be prescriptive. Decisions are made collectively at the MDT to provide a forum for consultation with all relevant specialists. This allows all treatment options to be considered and appropriate plans made, in order to advance the patients' pathway.

1.7 MDT Members

Please refer to individual Terms of Reference Documents for each of the 3 MDTs in Leeds, Bradford and York.

1.8 Research

The Head & Neck MDT teams across WY&H are committed to high quality research and support a wide variety of local, national and international trials. These are both surgical and oncological. The Specific trials change fairly frequently and therefore it is not pertinent to detail those clinical trials currently taking place in this document.

2 Patient Pathway

2.1 The Patient Pathway

GP/GDP to Cancer Unit:

Fast track referral services have been set up in each of the network Trusts.

Guidelines for urgent referral are:

Hoarseness persisting for > 6 weeks
Ulceration of oral mucosa persisting for >3weeks
Oral swelling persisting >3weeks
All red or red and white patches of the oral mucosa
Dysphagia persisting for 3 weeks
Unilateral nasal obstruction particularly when associated with purulent discharge
Unexplained tooth mobility not associated with periodontal disease
Unresolving neck masses for >3 weeks
Cranial neuropathies
Orbital masses

The level of suspicion is further increased if the patient is a heavy smoker or an alcohol drinker and is aged over 45 years and male. Other forms of tobacco use (chewing betel, gutkha, paan) should arouse suspicion.

Because of the potential work volume it is accepted that at this point head and neck surgeons in the unit are not specifically approached by the primary care team but a pool system is in place to ensure a rapid response to urgent referral. Naturally a GP or GDP may request specific urgent consultation if they feel appropriate. The need for education of GP's and GDP's is recognised. The Head and Neck Cancer Network also recognise the need for primary prevention and education of the public.

Network Referral Guidelines

There is a network agreed format for fast track referrals (see each individual MDT documentation for details)

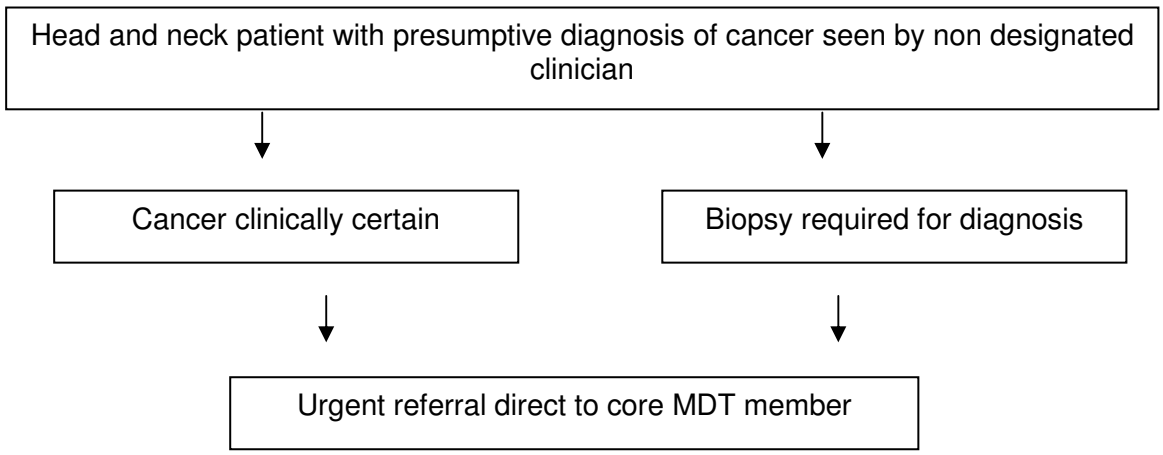
The network subscribes to a uniform policy approach adhering to the schema as agreed by the Chair of the Network and Chair of the NSSG (Head and Neck Group)

Routine Referrals

Routine referrals for patients with UAT symptoms that are not suspected cancer will be dealt with by each Trust within their normal referral processes:-

Internal referral guidelines for non designated hospital clinicians

Diagram of referral schema theme



Designated consultants and points of referrals

Leeds

Clinical Oncologists
Dr Satiavani Ramasamy (also Mid-Yorkshire)
Dr Patrick Murray (also Mid-Yorkshire)
Dr Mehmet Sen
Dr Kate Cardle (also Bradford)
Dr Karen Dyker (Leeds Paediatric & Teenage and Young Adult (TYA) patients, also Bradford)
Dr Robin Prestwich (also York)

ENT Surgeons
Mr Jamie Woodhead
Mr James Moor
Mr Amit Prasai

Maxillofacial Surgeons
Mr TK Ong
Mr Gillon Fabbroni
Mr Anastasios Kanatas
Mr Michael Ho (also visiting consultant Wakefield)

Plastic Surgeon
Mr Mark Liddington

Wakefield

ENT Surgeons

Mrs Helen Cruickshank
Mr Sinnappa Gunasekaran

Maxillofacial Surgeons
Mr Michael Ho (visiting consultant from Leeds)

Clinical Oncologists
Dr Satiavani Ramasamy
Dr Patrick Murray

Bradford

ENT Surgeons
Mr Sanjai Sood
Mr Chris Bem
Mr Dominic Martin-Hirsch

Maxillofacial Surgeons
Mr David Sutton
Mr Theo Boye
Locum

Plastic Surgeon
Mr David Watt

Clinical Oncologists
Dr K Dyker
Dr Kate Cardale

York

ENT Surgeons
Mr Andrew Coatesworth
Mr Andreas Nicolaides
Mr Frank Agada

Maxillofacial Surgeons
Mr Paul Whitfield
Mr Don Holt
Mr A Nicholas Brown

Clinical Oncologist
Dr Robin Prestwich

Please refer to individual pathway documentations for Leeds MDT (Leeds and Mid-Yorkshire Trusts), Bradford MDT (Bradford, Huddersfield, Calderdale and Airedale) and York MDT (York, Harrogate, and patients with Head and Neck cancer presenting to the Maxillofacial Surgery Service at Scarborough and Bridlington) for a more detailed list of individual hospitals' designated clinicians and distribution of individual guidelines.

Designated MDT for complex referrals

Complex tumours involving skull base are referred to Leeds MDT which has close links with the Craniofacial Team at Leeds.

Cancer Unit Diagnosis:

Out patient diagnosis may be strongly suspicious of a malignant process. The patient will need to undergo formal examination, staging and biopsies. If possible this should be done by the nominated surgeon head and neck surgeon for that Trust. A smooth inter consultant pathway between disciplines (e.g. general surgery), or within specialties (e.g. ENT), to one of these surgeons, allows more accurate staging, communication with the non medical clinicians (e.g.: psychological support from the clinical nurse specialist), valid, familiar and patient centred presentation at the MDT, and seamless continuity of care at follow up. It enhances expertise, training, patient and carer communication, and should speed up the next step of the patient pathway by organisation of appropriate radiology, pathology etc. Concerns regarding de-skilling of other staff, dependence on a single chain, cover etc. are anticipated and recognised.

Clearly some patients will only be diagnosed post biopsy and then referred to the nominated surgeon or MDT, which requires the process to be clear. The psychosocial needs of the patients and their carers are paramount and a network of support via out patient staff and the clinical nurse specialists is in place and accessible throughout the parts of Yorkshire covered by the region. Some of that support will naturally be via the GP, and it is therefore vital that rapid communication of the cancer diagnosis is possible. Each Trust is committed to supporting that link and a variety of possibilities are being examined.

Radiological investigations should be requested and organised centrally where possible because of the complexity of modality, technique and reporting, however it is accepted that there will be a significant proportion of Radiological investigation undertaken in locality hospitals. The radiologist is an integral part of each MDT. Although cancer unit pathology may be sufficient there may be instances when centralised review is required, and in practice most patients have MDT specific review. Please see the Head and Neck Radiology and Head and Neck Pathology Guidelines. Each Trust is committed to supporting that link.

Clinical assessment of the patient including formal staging, anaesthetic assessment where indicated should be undertaken prior to discussion at the MDT.

The Multi-Disciplinary Meeting (MDT):

The patient is referred to the MDT via the appropriate co-ordinator who is responsible for the administrative support to the meeting and the out patients clinic. Each MDT also has a clinical leader. A record is kept of the attending members of the team and a summary of the discussion supplemented by proposals for the next step in the patient pathway. This may include recommendations for treatment, but they need to be incorporated with the clinical picture. Treatment options are then discussed at the clinic with the patient by the relevant clinicians, preferably a Consultant, in the presence of the carers. Recommendations are made and alternatives discussed before any final patient decision is made and implemented. Relevant input from the MDT nurses, CNS, dietitian and SALT are vital, including a holistic needs assessment. Time should be given for questions, counselling and support, backed up

by written information if at all possible. Prior to any treatment being undertaken the patient would be seen again by the relevant clinician for further explanation and consent.

A formal pre treatment assessment should normally be undertaken by the H&N CNS, Dietitian and SALT, as well as assessment by the teams' consultant restorative dentist prior to commencement of any treatment. The detail as to how this takes place will vary between MDT's. The need for prophylactic feeding tube is also considered.

If an operation is advise.d the surgical team can proceed from this point. Only surgeons that are part of the core or extended MDT should routinely be involved in the management of these patients. That includes surgeons working under their supervision i.e. trainees. The surgical flow between units, satellite centres with MDT and the Leeds Cancer Centre has been agreed and is discussed below.

Post operatively the pathological specimen should be examined centrally and reported. Readers are referred to the WY&H CA (formerly YCN) H&N pathology Guidelines for detailed explanation. The patient is then reviewed at the MDT with a view to a decision on adjuvant treatment.

If radiotherapy is the primary treatment patients will obviously join the decision tree at this point. Following patient discussion the mould room request and radiotherapy booking form will be filled in at clinic and signed by the consultant clinical oncologist. The clinic nurses will supplement the information by further verbal and written explanation; this is intended to reinforce and inform patients and their carers and is not a substitute.

When relevant and either treatment are equally effective, patients are offered surgery and radiotherapy options.

There are plans to offer a sentinel lymph node biopsy service as outlined in quality statement 3 (NICE 2017) in Leeds. Until that is established, individual cases can be referred.

Follow up:

On completing treatment the patients are referred back to the relevant MDT follow up clinic – the structure of which varies across the Network. For the patient's convenience much of the follow up should be performed as close to home as possible. This needs to be balanced with the need for audit and follow up by the treating oncologist. Non medical members of the team will often follow the patient in parallel or in nurse led clinics where applicable. Patients or the carers can request urgent clinic follow up at any time. If a patient develops recurrence or a new cancer the GP will be informed as quickly as possible. Referral pathways are well established at each MDT to the local palliative care team.

Data Collection:

Administrative support for the collection of the national minimum data set has been funded centrally and is being addressed in each of the MDT. The hope is that a centralised database can be set up, inputted and interrogated by the network. By unifying the patient pathway no matter where they live in W. Yorkshire or which MDT they attend it is hoped to provide equity of care throughout the network. The pathway aims to be patient centred and to achieve the targets laid out in the National Cancer plan. It is dynamic and with likely personnel changes may need reviewing in the near future.

The cancer dataset from all 3 MDTs is fed into the national (formerly DAHNO/HANA) audit system.

Surgical Referral Pathways:

Leeds

Leeds operates both as a cancer unit and a cancer Centre, and the MDT is weekly. The two satellite MDT's at York and Bradford also meet weekly. All have defined core and extended membership with extensive links to primary care, palliative care and the referring cancer units. The units all offer diagnostic and follow up service. Review of current local facilities and expertise, along with rationalisation on the basis of patient numbers has led to consensus agreement on the following:

Surgical procedures which should exclusively be carried out at the Leeds Cancer Centre:

Skull base surgery
Extensive surgery for paranasal sinus tumours
Total Pharyngo-laryngectomies with reconstruction
Tumours that extend close to the skull base or other high risk procedures should also be considered for cancer Centre referral.

Mid Yorkshire

All cases are discussed at the central Leeds/Mid Yorks MDT (Both ENT surgeons listed above are core members). All surgical resection procedures will be carried out in Leeds. Diagnostic procedures can be carried out in Pinderfields Hospital.

The radiologists attend the Leeds MDT and MR and CT facilities are available with their expert review.

A full complement of AHPs exist within the Mid-Yorkshire service on site at Pinderfields Hospital, the Cancer Nurse Specialist and Laryngectomy Nurse Specialist attend and are core members of the combined weekly MDT.

York

York supports a wide range of ablative and reconstructive surgery with 2 team operating when required. Currently all patients with hypopharyngeal cancer whose surgical needs would require a Total Pharyngo-laryngectomy with reconstruction are discussed in the Leeds MDT. Some patients who are under the geographical surgical umbrella of York may have their radiotherapy at Hull.

Bradford

Bradford Head and Neck MDT provide a wide surgical range of surgery with up to four full-day lists each week, regular diagnostic lists with microsurgical teams, laser facilities and temporal bone surgery.

Calderdale and Huddersfield

Diagnostic and follow up facilities exist at Calderdale & Huddersfield (CHT), with all major resections being carried out in Bradford. There is one ENT surgeon and one OMF surgeon with sessions at CHT attending the Bradford MDT; a joint H&N follow-up clinic takes place weekly at Huddersfield

The core member (Head & Neck Cancer Group) Maxillofacial surgeon has sessions in Bradford.

Maxillo-Facial core members of the Bradford Head and Neck MDT have sessions at Calderdale and Huddersfield.

3 Head and Neck Cancer

The management of head and neck cancer has already been the subject of extensive review by an expert multi-disciplinary team in 2016 and endorsed by seven medical specialty organisations involved in head and neck cancer care. Our management may vary for a variety of reasons from the guidelines. However, we endorse and follow the guidelines as published – see link for open access provided earlier on page 6.

https://www.jlo.co.uk/news/head-and-neck-cancer-united-kingdom-national-multidisciplinary-guidelines

4 Thyroid Cancer

Although there are strong links there is a separate thyroid cancer MDT. The management of thyroid cancer has already been the subject of extensive review and the head and neck group endorse and follow the guidelines from the The British Thyroid Association. There is a section in the 2016 guidelines above.

5 Palliative & End of Life Care

5.1 Definitions

This section was updated in May 2017

Palliative care is part of supportive care. It embraces many elements of supportive care.

Palliative & End of life care is care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last year(s) of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

The Department of Health (2008) definition of end of life care states that it includes:

- Adults with advanced, progressive, incurable illness (e.g. advanced cancer, heart failure, COPD, stroke, chronic neurological conditions, dementia);
- Care given in all settings (e.g. home, acute hospital, ambulance, residential/nursing care home, hospice, community hospital, prison);
- Care given in the last year(s) of life
- Patients, carers and family members (including bereavement care).

End of Life Strategy, Department of Health 2008
National Council for Palliative Care Services 2006

5.1 Who Provides Palliative / End of Life Care?

Palliative / end of life care is provided by two distinct categories of health and social care professionals:

- All health care and social care professionals providing the day-to-day care to patients and carers in any care setting
- Those who specialize in palliative care (consultants in palliative medicine and clinical nurse specialists in palliative care, for example) who care for palliative care patients who have complex needs

Those providing day-to-day care should be able to:

- Assess the care needs of each patient and their families across the domains of physical, psychological, social spiritual and information needs
- Meet those needs within the limits of their knowledge, skills, competence in palliative care
- Know when to seek advice from or refer to specialist palliative care services

Training and education in the skills required for palliative / end of life care should be available to and undertaken by all health and social care professionals.

The national strategy *Ambitions for Palliative and End of Life Care 2015-2020* sets out the vision to improve end of life care through partnership and collaborative action between organisations at local level throughout England.

More information can be found at: http://endoflifecareambitions.org.uk/

For more information about local improvements, frameworks, tools to support best practice please contact your local End of Life Care Lead or Specialist Palliative Care Team.
One aspect of care is to discuss with individuals, if they wish, their preferences regarding the type of care they would wish to receive and where they wish to be cared for in case they lose capacity or are unable to express a preference in the future. This is the process of Advance Care Planning (ACP).

An ACP discussion might include:

- the individual's concerns and wishes,
- their important values or personal goals for care,
- their understanding about their illness and prognosis,
- their preferences and wishes for types of care or treatment that may be beneficial in the future and the availability of these.

Such discussions can also inform shared decision-making regarding treatments with palliative intent. Local arrangements for recording this information for each individual patient will differ. Many services are developing/have developed Electronic Palliative Care Co-ordination Systems (EPaCCS) where by this information can be shared across professionals and settings (e.g on SystmOne). Contact your local specialist palliative care team for more information.

5.2 Specialist Palliative Care

Is provided by specialist multidisciplinary palliative care teams in services or units whose core specialty is palliative care (for example hospices, community or hospital palliative care teams). The specialist teams should include palliative medicine consultants and palliative care nurse specialists together with a range of expertise provided by physiotherapists, occupational therapists, dieticians, pharmacists, social workers and those able to give spiritual and psychological support.

Eligibility for referral to specialist palliative care services is based on patient need not diagnosis. The agreed criteria for referral are as follows:

1. The patient has active, progressive and usually advanced disease for which the prognosis is limited (although it may be several years) and the focus of care is quality of life.

2. The patient has unresolved complex needs that cannot be met by the caring team, for example:
   - Uncontrolled or complicated symptoms (e.g. symptoms not adequately controlled within 48 hours by the referring team, or sooner if causing overwhelming distress).
   - Complex psychological/emotional difficulties.
   - Complex social or family issues.
   - Difficult decision making about appropriate future care.

Patients fulfilling these criteria should be referred to and assessed by a member of the specialist palliative care team.

The subsequent care package will be dependent on this assessment and should be made in agreement with the patient, carer(s) and referring team. It is not appropriate for specialist palliative care services to be committed to patients by professionals outside these services.

Equally, specialist services should ensure that the assessment process is accessible and responsive to patients in need.

The level of specialist palliative care support required may fluctuate. Shared care of patients between the specialist palliative care professionals and the referring team (for hospital patients) or the primary care team (for patients at home / care home) is usually appropriate. Timely and effective communication is essential in these situations. For these patients advice from specialist palliative care services on a 24 hour basis should be available in all care settings.
Sometimes the specialist palliative care consultant and team may take the lead role in patient care, usually in a specialist in-patient unit (hospice) or designated specialist palliative care beds.

Referral systems for specialist palliative care services vary in different areas. They should be clear to all local referring consultants and primary care teams.

5.3 Further Links and Information

Contact the local Specialist Palliative Care Team for further information

5.4 Directory of West Yorkshire & Harrogate Cancer Alliance Specialist Palliative Care Services

The Directory has been checked and updated in May 2017

Bradford, Airedale, Wharfedale and Craven
Bradford Teaching Hospitals NHS Foundation Trust
Airedale NHS Foundation Trust
NHS Bradford, Airedale, Wharfedale and Craven
Website: www.palliativecare.bradford.nhs.uk

Airedale General Hospital Palliative Care Team	Tel	01535 292184 01535 295016
	Fax	01535 295036
Sue Ryder Care – Manorlands Hospice (Oxenhope)	Tel	01535 642308
	Fax	01535 642902
Bradford Teaching Hospitals Palliative Care Team	Tel	01274 364035
	Fax	01274 366851
Bradford Community Palliative Care Team	Tel	01274 323511
	Fax	01274 215660
Marie Cure Hospice (Bradford)	Tel	01274 337000

	Fax	01274 337095
Out of Hours Advice via on-call Palliative Medicine Consultant via Marie Curie Hospice / Manorlands Hospice	Tel	01274 337000
	Tel	01535 642308

Calderdale and Huddersfield
Calderdale & Huddersfield NHS Foundation Trust
NHS Calderdale
NHS Kirklees
Web: http://www.cht.nhs.uk/services/clinical-services/palliative-and-end-of-life-care/specialist-palliative-care/

Calderdale Royal Hospital & Huddersfield Royal Infirmary Palliative Care Team	Tel	01484 342965
	Fax	none
Calderdale Community Palliative Care Team Left message to confirm fax	Tel	01422 310874
	Fax	01422 378425
Overgate Hospice	Tel	01422 379151
	Fax	01422 384210
Kirkwood Hospice and Community Palliative Care Team	Tel	01484 557906
	Fax	01484 557918
Out of Hours Advice via Hospices	Tel	01422 379151 01484 557900

Harrogate and District
Harrogate NHS Foundation Trust
NHS North Yorkshire and York
Website: https:// https://www.hdft.nhs.uk/services/palliative-care/

Harrogate Hospital and Community Palliative Care Team	Tel	01423 553464
	Fax	01423 555763
St Michael's Hospice	Tel	01423 872658
	Fax	01423 815454
Out of Hours Advice via Hospice	Tel	01423 879687

Leeds
Leeds Palliative Care
Website: www.leedspalliativecare.co.uk

Leeds Teaching Hospitals NHS Trust Specialist Palliative Care Team	Tel	0113 2064563
	Fax	0113 2064863
Sue Ryder Care - Wheatfields Hospice and Community Palliative Care Team (West Leeds)	Tel	0113 2787249
	Fax	0113 2302778
St Gemma's Hospice and Community Palliative Care Team (East Leeds)	Tel	0113 2185500
	Fax	0113 2185524
Out of Hours Advice via SJUH Switchboard	Tel	0113 2433144

Mid Yorkshire
Mid Yorkshire Hospitals NHS Trust
NHS Wakefield District
Kirklees PCT
Website: https://www.midyorks.nhs.uk/palliative-care1

Dewsbury Hospital and Community Palliative Care Team	Tel	01924 816052
	Fax	01924 543883
Dewsbury Day Support and Drop-in (Rosewood Centre)	Tel	01924 512039
Mid Yorkshire Hospitals NHS Trust Palliative Care Team	Tel	01924 543801
	Fax	01924 543883
Pontefract Community Palliative Care Team (Prince of Wales Hospice)	Tel	01977 781456
	Fax	01977 796209
Prince of Wales Hospice (Pontefract)	Tel	01977 708 868
	Fax	01977 600097
Wakefield Hospice	Tel	01924 331400
	Fax	01924 362769
Out of Hours Advice via Pinderfields Hospital Switchboard	Tel	01924 541000

York
York Hospitals NHS Foundation Trust
NHS North Yorkshire and York

https://www.yorkhospitals.nhs.uk/our_services/az_of_services/palliative_care/

York Hospital Palliative Care Team both correct	Tel	01904 725835
	Fax	01904 726440
Community Palliative Care Team	Tel	01904 724476
	Fax	01904 777049
St Leonard's Hospice	Tel	01904 708553
	Fax	01904 704337
Out of Hours Advice via Hospice	Tel	01904 708553

6 Management of Less common problems

6.1 Teenage and Young Adult Service – Age 13-24 years

Based at St James University Hospital - all local patients can be referred.
Dr Karen Dyker (KED) is the core member of the Leeds H&N MDT with a special interest in Head & Neck TYA patients.

Please refer to the TYA MDT as detailed below and inform KED of the patient, in order for KED or representative to attend Leeds Head & Neck MDT to discuss patient.

Referral Criteria

Aged between 13 and 24 years, with a diagnosis of a haematological or solid tumour malignancy. The team aims to work in collaboration with the referring MDT's and Specialist Nurses.

- The team would ideally like to meet the patient/family/partner at the initial diagnosis consultation wherever possible.

- To have communication with the patient/family within 2 working days of referral from the nursing/medical team. The patient/families are contacted and a meeting arranged to discuss any issues with which they may need help. This may be in the form of psychosocial support and/or financial, educational, employment or relationship advice. They also have direct access to professionals who are able to answer any questions about their disease and treatment. This is either from the professionals concerned, or by referral to others who can answer their questions.

- Offer a place of contact or any help, either practical or social, five days a week, with an answer phone to receive any messages.

- Visits from the team whilst the patient is hospitalised.

- Liaison with the professionals who are caring for the patient, to help with any developing issues.

- An offer to attend outpatient appointments with them, to help explain any difficult issues or for moral support.

- To be their advocate.

- Access to a local network of young people with cancer, and their families. There is a very active Social Support Group available to all patients and friends. For the older patients a Young Adult Cancer Support Group is available which meets monthly at the Macmillan Centre, St. James's Hospital.

- Access to a developing National Network of young people who meet once a year in the form of a conference.

- In the event of a patient's death, bereavement follow-up is offered to the families. This may include attending the funeral to represent the hospital, home visits and, if necessary, return visits to the hospital to discuss any unresolved issues with the medical staff. There is also a bereavement support group – for families, partners and friends.

All referrals to the service will be discussed at the TYA MDT, held weekly on a Thursday at Level 7, Bexley Wing, SJUH 2.45-3.30p.m.

Presentation will include age, diagnosis, referring MDT, place of treatment, professionals involved and psychosocial aspects. Treatment, diagnostic decisions or pathology will NOT be discussed. The referring professionals will be informed of such MDT's and will be most welcome to attend.

Method of referral to TYA Service

Address: TYA Service
Teenage Cancer Trust Service
Ward 10
St James's University Hospital
LEEDS
LS9 7TF

Contacts: Sue Morgan, Macmillan Clinical Nurse Specialist TYA, MDT Lead
Telephone: 0113 3926285

Dr Karen Dyker, Consultant Clinical Oncologist, SJUH
Telephone: 0113 206 7870

Sally Burnell, Oncology Nurse Specialist TYA
Telephone: 0113 2066204

Sarah Horvath, Sargent Social Worker TYA
Telephone: 0113 2066453

Cat Austin, Carrie Galliford Teenage Activity Co-ordinator
Telephone: 0113 2064639

Kirsty Faircliffe, MDT Co-ordinator
Telephone: 0113 3926286
Fax: 0113 39 26375

6.2 Management of Head and Neck Sarcomas

A small number of patients present with head and neck sarcomas. Both the Head & Neck and Sarcoma MDTs agree the patients should be discussed at both specialist MDT.

Within the head and neck network there are three MDTs all of whom see patients in clinic after the MDT discussion. The network sarcoma MDT is centralised in Leeds. It takes place

weekly on a Monday afternoon. The current lead clinician is Kieran Horgan. It is a very successful and high calibre MDT which discusses a large number of patients. Only a proportion of patients are seen and treated entirely by that team and there are links with head and neck, GI and gynaecology.

The sarcoma team offers:

- Specialist histopathological review and classification of Head & Neck soft tissue sarcomas.
- A view of the natural history of the disease and the prognosis
- An opinion on the role of chemotherapy, surgery and radiotherapy both at initial presentation and following each treatment modality e.g. the need for post operative radiotherapy.

Pathologists

Dr Will Merchant and Dr Sara Edwards
They will provide pathology review and confirmation for soft tissue sarcomas.
They will send possible bone sarcomas to Prof Robin Reid in Glasgow for pathology review and confirmation.

Medical Oncologists

Dr Dan Stark and Dr Maria Marples
They are the central contacts for the non surgical oncology group within the Sarcoma MDT
They will liaise re: the appropriate chemotherapy neoadjuvantly, adjuvantly and in the palliative setting.
Tel: 0113 206 5417

Clinical Oncologists

Dr Rob Turner and Peter Dickinson
They will liaise with the head and neck clinical oncologists, who will undertake the radiotherapy element

Sarcoma MDT co-ordinator (post currently unfilled)
Tel: 0113 392 6524
Fax: 0113 392 5364

Principles

As patient identification at the earliest stage is by the histopathologist the opportunity exists for them to initiate central pathology review in preparation for the sarcoma MDT as that will be the rate limiting step. The patient should proceed with the appropriate radiology of MR or CT scanning depending on the primary site and CT scanning of the thorax. In addition bone scanning may be required and OPT. The patient should be seen in the head and neck MDT and referred to the sarcoma MDT via their co-ordinator.

Surgery and radiotherapy should be within the appropriate head & neck MDT setting. The head and neck team have all of the relevant support as regards specialist nurses, dietitians, speech therapist and dental support.

The role of radiotherapy and details of dose and fractionation should be discussed by the head and neck clinical oncologists with their sarcoma counterparts. This has proved a satisfactory working relationship in the past.

The resection of bone tumours is carried out by the agreed head and neck surgeons, unlike bone tumours arising in other anatomical sites, who are referred to Royal Ofthopaedic Hospital Birmingham.

For many soft tissue sarcomas the initial management is surgery. Post operative radiotherapy is considered for all high grade sarcomas and if positive margins, for intermediate and low grade sarcomas.

High grade sarcomas of small round blue cell type, embryonal and alveolar rhabdomyosarcomas, and osteosarcomas of the head and neck often require pre-operative chemotherapy followed by surgery, then post-operative chemotherapy and/or radiotherapy.

Discussion with Dr Stark or Dr Marples is vital to get the timing of chemotherapy, the number of cycles and the assessment of response accurate. Contact by telephone (as soon as a case of high grade sarcomas of small round blue cell type, embryonal and alveolar rhabdomyosarcomas or osteosarcomas of the head and neck are suspected) seems to be the best form of communication followed up by secretarial letters so that the discussion becomes part of the patient record.

Re assessment
Reassessment by radiology and planning for potential surgery is necessary. It is important with neo adjuvant chemotherapy that the timing of the radiology is then coupled by MDT review. From the medical oncologist point of view this radiological review is primarily aimed at ensuring both clinical and radiological response and the absence of chest metastases. However from the head and neck point of view the anatomical boundaries dictate the possibility of functional surgery. It is therefore advised that the radiology is performed within the referring head and neck MDT, because of the head and neck radiology expertise.

Specific Age Groups

If<13 refer to the paediatric solid tumour MDT
Barbara Pymer Tel: 0113 2066955
MDT Co-ordinator Fax: 0113 2470248

If 13-24 refer to the TYA MDT
Kirsty Faircliffe Tel: 0113 3926286
MDT Co-ordinator Fax: 0113 39 26375

If >25 refer to the Sarcoma MDT
MDT Co-ordinator Tel: 0113 3926524
Fax: 0113 3925364

Summary

Patient Identified as having a Sarcoma

- Pathologist informs referrer and also refers to sarcoma MDT (by fax or phone see above)

- If bone sarcoma, pathologist refers to Robin Reid in Glasgow for pathology review
- Referrer ensures discussion at Head and Neck MDT and referral to sarcoma MDT (by fax or phone see above)
- Consider referring to Paediatric or TYA service and MDT
- Referrer discusses role of neoadjuvant chemotherapy with Dr Stark or Dr Marples by phone as timing usually tight
- Decision from sarcoma MDT (documented on PPM) within 2 weeks re:
  - Pathology review (STS only)
  - Chemotherapy opinion
- Head & Neck MDT responsible for surgery
- Head & Neck MDT responsible for radiotherapy, in discussion with Dr Turner or Stuart if required

Follow Up
The follow up should be conducted by the head and neck team but copy letters to the sarcoma team are important. Patients who have had chemotherapy as part of their management should have copy letters addressed to Dr Stark.

No routine scanning is advised but CXR surveillance should be:
- Three monthly in year one
- Four monthly in year two
- Six monthly up to year five

The sarcoma improving outcomes guidance was presented in March 2006. The guidance refers to diagnostic pathways for head and neck sarcomas, co-ordination and shared management between the head and neck and sarcoma team but little detail. This documents goes some way to develop our co-ordinated approach across the region.

6.3 Guidelines for Mucosal Melanoma (including Radiotherapy)

All our patients with melanoma are discussed in both Head and Neck Cancer MDT as well as melanoma MDT. Please see melanoma section of Head and Neck Cancer Guidelines 2016.

7 Allied Health Professionals

Introduction

The IOG (2004) recommended that CNS, Dietitian and SALT be core members of the MDT. All Head and Neck cancer patients receive pre and post treatment holistic assessment by the CNS and AHP teams. The Supportive and Rehabilitative pathways for Nursing, Dietetic and Speech Therapy services, in appendix three four and five, outline the interventions offered to the majority of patients.

8 Anatomical definitions and stage groupings for H&N cancer sites

We are in the process of changing over to the latest TNM staging (see eighth edition of the American Joint Committee on Cancer (AJCC) Staging Manual, Head and Neck Section, 2016). This document introduces significant modifications from the prior seventh edition. Significant changes included human papillomavirus associated oropharyngeal cancer, reorganization of skin cancer (other than melanoma and Merkel cell carcinoma), changes to the tumor (T) categories for oral cavity, skin, and nasopharynx; and the addition of extranodal cancer extension to lymph node category (N) in all but the viral-related cancers and mucosal melanoma.

9 Appendix 2: Restorative Dentistry / Oral Rehabilitation

9.1 Introduction

In patients diagnosed with head and neck cancer, oral and dental health often has a significant effect on quality of life. For patients planned to receive radiotherapy fields that include the maxilla or mandible, establishing pre-treatment dental health can lead to improved patient comfort, reduce the incidence of interruptions to radiotherapy due to dental problems and decrease the incidence of osteoradionecrosis. Chemotherapy can also cause acute mucosal and haematological toxicity, and this can be exacerbated if delivered at the same time as radiotherapy treatment.

Xerostomia (dry mouth) tends to particularly occur when radiation fields include salivary glands, most notably the parotid glands. Such xerostomia is often permanent and often results in increased dental caries, periodontal (gum) disease, oral discomfort, taste disturbance, eating difficulties and poor healing following dental surgical procedures.

Trismus may occur in patients as a result of radiotherapy or surgical intervention in some cases. This can further complicate post-treatment oral and dental care.

Osteoradionecrosis (ORN) is a potentially serious condition that can be related to radiotherapy fields that include the maxilla or mandible. The incidence of the condition is greatest in the mandibular molar region. Risk is greatest at doses over 60Gy and with concomitant chemotherapy.

Surgical intervention (and also radiotherapy) have the potential to significantly alter the oral anatomy. Such alterations can make future dental treatment complex and frequently necessitates assessment and/or treatment by a specialist in Restorative Dentistry. Oral rehabilitation can be technically difficult, requires specialist knowledge and in some cases necessitates the use of complex treatment including dental implants, obturator or facial prostheses. In certain circumstances oral/dental rehabilitation is either not possible or not advisable.

9.2 Referral criteria

9.2.1 Pre-treatment

Aims of Pre-treatment Restorative Assessment

- Ensure oral rehabilitation is considered and provisionally planned prior to ablative surgery
- Avoid unscheduled interruptions to chemotherapy/radiotherapy due to dental complications by making the patient dentally fit prior to commencing cancer treatment

- Reduce risk of ORN by assessing prognosis and maintainability of remaining dentition
- Enable a oral care preventative regimen to be tailored to the patient
- Allow an explanation of potential short and long term oral/dental problems which the patient may encounter during their cancer treatment

Restorative dentistry pre-treatment assessments are encouraged for:

- Patients requiring an assessment to consider oral rehabilitation, particularly those planned for surgical intervention that will alter oral anatomy
- Dentate patients requiring radiotherapy where the treatment field includes any part of the maxilla, mandible or salivary glands
- Patients with specific dental concerns

Pre-treatment assessment should be carried-out by a Consultant in Restorative dentistry or an appropriately trained and experienced dental surgeon from the Restorative team.

9.2.2 Post-treatment

Following treatment for head and neck cancer, dental review should be encouraged particularly for:

- Patients who have received radiotherapy that has included any part of the maxilla, mandible or salivary glands in the treatment field.
- Patients who have altered oral anatomy.
- Patients with specific dental / oral concerns.
- Patients who have had complex restorative treatment following their cancer treatment such as provision of an implant retained prosthesis, or an obturator.

9.3 Role of the Consultant in Restorative Dentistry

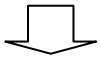
- To provide dental / oral advice and treatment as appropriate to Head and Neck cancer patients.
- To provide advice and guidance to general dental practitioners and other professionals on the oral care of Head and Neck cancer patients.
- To liaise closely with other MDT members.
- To provide specialist training for appropriate staff.

9.4 Appendix 3: Supportive Care and Rehabilitation Pathway for Patients with Head and Neck Cancer Nursing Input

Pre-Diagnosis (Referral and initial investigation) **Out Patient Staff**	• Commence Holistic assessment, as appropriate refer on to Dietitian, Speech & Language Therapist (SALT) and Head & Neck Cancer Nurse Specialist (H & N CNS). • Provide information regarding further investigations and procedures. • Provide information on health promotion as appropriate, particularly around smoking cessation and reduction in alcohol consumption.

At the time of diagnosis (Pre-treatment assessment and management) **Out Patient Staff CNS** Appendix 3: Supportive Care and **CNS Local**	**Diagnosis** • Bad news broken by senior clinician. • Head and Neck CNS present to provide psychological support to patient and carer, if CNS not present Outpatient Staff to notify CNS by completing a breaking bad news proforma. • Holistic Needs Assessment completed by the CNS • Patient information given in relevant format, Key Worker contact details and role explained plus information regarding the MDT meeting and clinic. • GP notified of diagnosis within 24 hours. • Inform Multi Disciplinary Team (MDT) Co-ordinator of new diagnosis. • Holistic assessment continues; if appropriate refer to Dietitian, SALT, District Nurse or relevant Health Care Professional. • Information given about disease process and expected treatment plan. • Relevant investigations ordered and next appointment given to patient. • Provide information on health promotion as appropriate, particularly around smoking cessation and reduction in alcohol consumption. **MDT/Treatment Decision** • Act as patient advocate during treatment plan discussion. • Be present when treatment discussed with patient. • Ensure patient referred to relevant Health Care Professionals, for example Consultant Restorative Dentist, Gastrostomy Team, Dietitian, SALT, Primary Health Care Team (PHCT), other support services. • Provide appropriate information for treatment plan. • Ensure appointment made for combined Pre Treatment Assessment (PTA). • Holistic assessment continues. **Pre Treatment** • Combined PTA with patient/carer to include SALT, Dietitian and H & N CNS with input from any other Allied Health Care Professionals (AHP's) as required, meeting place to be suitable for confidentiality, respect, dignity and comfort of patient/carer). • Update Holistic Needs Assessment, including physical, psychological and social needs using the distress thermometer • Assess patient and carers understanding of the treatment plan discussed at the MDT clinic. • Explain the proposed treatment, discussing logistics and side effects of non

	surgical treatment plus post operative care for patients having Surgery. • Refer complex needs patients to the Radiotherapy Support team • Ensure other assessment referrals have been completed, for example; Consultant Restorative Dentist, RIG insertion arranged (if appropriate).Welfare Rights Referral. • Offer meeting with a patient(s) who have had same or similar experience. • Information given regarding the local support team • Provide information on health promotion as appropriate, particularly around smoking cessation and reduction in alcohol consumption. • Update sent to the GP



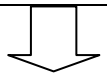
Treatment (Surgical and non-surgical) **Ward Nurse Out Patient Staff CNS**	**Surgical** • Pre operative assessment to identify physical, psychological and social needs post operatively and planning for discharge, building on holistic assessment. • Refer to SALT, Dietitian, Physiotherapist, Occupational Therapist, and other health care professionals as appropriate. • Ensure ongoing symptom management. • CNS to visit patients on the ward to offer psychological support • Communicate any concerns with the ward staff/medical staff or carers • Ward staff to liaise with District Nurses as required for discharge • Ward staff/CNS to liaise with the CNS/AHP's in the patients locality **Non Surgical** • Ensure ongoing symptom management; liaise with PHCT as appropriate. • Provide ongoing holistic assessment, and intervention as appropriate. • CNS to provide psychological support • Liaise with local H & N CNS re complex needs patients when discharge planning, or end of treatment. • Arrange admission if appropriate. • Refer to Dietitian for nutritional needs, SALT for assessment of swallow as appropriate. • Provide ongoing information to patient carers re treatment side effects and management. • Provide information on health promotion as appropriate, particularly around smoking cessation and reduction in alcohol consumption. • Refer Leeds patients to the Local Support team once treatment completed

9.5 Appendix 4: Supportive Care and Rehabilitation Pathway for Patients with Head and Neck Cancer Salt Input

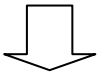
Pre-Diagnosis (Referral and initial investigation)	• Input from Speech and Language Therapist (SALT) for those patients identified with swallowing, speech or voice problems (referral from MDT required)

At the time of diagnosis (Pre-treatment assessment and management)	**MDT/Treatment Decision:** • To identify and advocate for patients/carers who experience barriers to communication, and to ensure appropriate communicative supports are considered and put in place. • Input from Speech and Language Therapist (SALT) for those patients identified with swallowing, speech or voice problems **Pre-Treatment** • Combined Pre Treatment Assessment (PTA) with patient/carer to include SALT, Dietitian and Head and Neck Cancer Nurse Specialist (H & N CNS) with input from any other Allied Health Professionals (AHP's)/ Social Worker as required, (meeting place to be suitable for confidentiality, respect, dignity and comfort of patient/carer). • Identify patient's with compromised ability to understand and express verbal and written language and provide appropriate communicative supports as appropriate • Explain role of SALT in both acute treatment and rehabilitation post treatment contexts. • Explain the proposed treatment/s and the anticipated impacts on speech, voice, eating and drinking and assess patient/carers understanding of this impact • Offer meeting with a "buddy"/patient/s who have had same or similar experience (variation across region in access to "buddy" system) • Complete and document baseline swallow and communication screening measures/assessments • Where indicated from baseline screening assessment, to undertake comprehensive assessment and any specialist investigations to detect any dysfunction of speech/voice/swallow and introduce short term strategies/techniques to deal with the immediate deficit e.g. communication aid, modifications in oral intake, alternative forms of feeding. • Offer clinical advice, information, and support to patient and carers related to eating, drinking, swallowing, communication and voice problems. • Develop care plan with appropriate goals and aims for Pre and Post treatment intervention. • Assess suitability for surgical voice restoration including cognitive, visual and auditory function and manual dexterity for laryngectomy patients. • Refer to Centre SALT if appropriate. • Refer to other services, where appropriate.

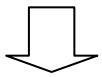
Treatment (Surgical and non-surgical)	• Liaise with Multi Disciplinary Team (MDT) and other health professionals • Liaise with treating Consultant regarding timing and suitability for direct SALT input throughout treatment • Maintain communication and contact with patient/carer regarding role of SALT and purpose/goals of intervention during treatment • Evaluate the neuroanatomy and physiology of the oral, pharyngo-oesophageal and laryngeal mechanisms. • Undertake full assessment which may include complex interventions, of speech, voice, eating and drinking and swallowing. • Communicate results of above assessment with patient, carer and MDT team • Instruct patient in therapeutic techniques and assist patient to maintain speech, voice and swallowing as treatment progresses. • Carry out investigations e.g. Nasendoscopy, Videofluoroscopy and Taub Test where required for effective management. • Assess timing and ability for surgical voice restoration training, where appropriate. • Refer to Unit SALT post treatment.



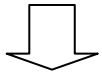
Post active treatment (After care and rehabilitation)	• Liaise with MDT and other health professionals. • Joint post treatment clinic with patient/carer to include SALT, Dietitian and H & N CNS with input from any other AHP's/ Social Worker as required (meeting place to be suitable for confidentiality, respect, dignity and comfort of patient/carer). • Local therapists to be in attendance at the specialist treatment centre for review clinics involving their patients. Where this is not possible, ensure timely two way exchange of information between centre and local team. • Ensure means of non-verbal communication is established where necessary and provide a communication aid if appropriate, including ongoing maintenance and servicing. • Be available to provide timely specialist advice /input /training, if required e.g. Taub Test, Videofluoroscopy, FEES/FNE, valve care/use/changes, to patients/carers/staff as appropriate. • Provide training to other health care professionals as and when appropriate. • Ensure means of non-verbal communication is established, where necessary and provide a communication aid if appropriate. • Set goals of intervention to facilitate neuromuscular recovery / adaptation. • Communicate SALT care plan with named SALT within the Local Support Team. • Provide ongoing assessment and review of function for speech, voice, eating and drinking and swallowing. • Provide detailed discharge report to local SALT, where appropriate. • Provide education and training to local named SALT as appropriate. • Take appropriate action within 2 weeks of referral to local team.



	• Provide ongoing advice and support to patient and carers, including videofluoroscopy. • Be aware of SALT care plan as communicated by the SALT. • Identify training needs as services develop and liaise with SALT. • Maintain and monitor patients' progress against care plan and revise, as appropriate. • Liaise / refer with other professionals, as required.



Survivorship/ Living with cancer/ Follow-up	• Patients to be offered follow up contact on an out patient basis. • Ongoing follow up support for Laryngectomees with electronic larynx devices and valves. • Patient support groups to have some professional input.



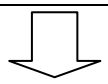
Palliative Care/ End of Life	• Follow the agreed Palliative Care Pathway for the locality

9.6 Appendix 5: Supportive Care and Rehabilitation Pathway for Patients with Head and Neck Cancer Dietetic Input

Pre-Diagnosis (Referral and initial investigation)	• ENT/MAXFACs Clinic Nurse to do nutrition risk screening and then follow local guidelines which may include giving first line dietary advice or referral to a Dietitian If referred Dietitian will • Assess nutritional requirements and factors affecting nutritional status • Produce individualised nutritional care plan and provide practical advice to patient and carers to improve nutritional status • Provide on-going review and monitoring of nutritional care plan • Refer to or liaise with other Allied Health Professionals (AHP's) for advice if indicated on assessment

At the time of diagnosis (Pre-treatment assessment and management)	• Carry out a combined, Pre Treatment Assessment with patient/carer to include Speech and Language Therapist (SALT), Dietitian and Head and Neck Cancer Nurse Specialist (Head & Neck CNS) with input from any other AHP's / Social Worker as required (meeting place to be suitable for confidentiality, respect, dignity and comfort of patient/carer). • Carry out full nutritional assessment including assessment of nutritional requirements and current factors affecting nutritional status • Produce individualised nutritional care plan and provide practical dietary advice, including written advice, to patient and relatives or carers to improve nutritional status • Provide on-going review and monitoring of nutritional care plan and provide support to patient, family and carers • Assess potential impact of treatment on patient's nutritional status and the need for further nutritional interventions including non-oral feeding • Liaise with Multi Disciplinary Team (MDT) and other health professionals regarding nutritional interventions such as prescribed nutritional supplements, modifications of food texture, and placement of enteral feeding tubes. • Provide advice and support to other health care professional, patients and relatives. • Provide ongoing support/education to patients/carers and health care professionals regarding enteral feeding methods. • Refer those patients having or planned to have home enteral feeding to the designated Home Enteral Feeding company and liaise with patients, relatives, carers and community staff as required

Treatment (Surgical and non-surgical)	• Local Dietitians will transfer Dietetic care to the Cancer Centre Dietitian if undergoing treatment at the Cancer Centre.
	• For patients not known to the Dietitian, the Clinic nurse/ward nurse to repeat nutritional screening and follow local guidelines to ensure that the patient has access to appropriate texture diet ordered by the ward staff, and is referred to the Dietitian if indicated.
	• On-going dietetic management and monitoring of nutritional status during treatment will include:
	  • Optimising nutritional status.
	  • Start/continue nutritional support interventions (oral/enteral/parental nutrition).
	  • Advice on specific diets including modification of texture and taking into account any relevant co-morbidities.
	  • Provide education regarding management of enteral feeding tubes and the administration of enteral feeds.
	  • Contribute to the coordinated discharge of patients requiring home enteral feeding and ensure referral to community services for continued support.
	  • Provide on- going advice on diet, texture modification and quantity of food based on treatment side effects and nutritional status.
	  • Start/continue enteral nutritional support and provide on-going monitoring, management and education regarding care.
	  • Liaise with home enteral feeding team and community staff for any changes to feeding regime.
	  • Liaise with patients and relatives or carers regarding any changes to the nutritional care plan.



Post active treatment (After care and rehabilitation) **Local Support Teams**	• Transfer dietetic care back from the Cancer Centre Dietitian to Local Support team Dietitian if has rehabilitation needs. • Carry out a combined post treatment assessment with patient/carer to include SALT, Dietitian and H & N CNS with input from any other AHP's / Social Worker as required (meeting place to be suitable for confidentiality, respect, dignity and comfort of patient/carer). • Inform Primary Care of prescription needs for supplements/feeds and nutritional care plans, and communicate follow up arrangements with GP. • Continue to monitor nutritional status and manage symptoms secondary to side-effects of cancer treatment. • Provide on-going advice on diet, texture modification and quantity of food based on treatment side effects. • Provide advice and support for enteral feeding tube dependent patients and those returning to diet. • Problem solve and signpost regarding feeding stoma site management and tubes • Liaise with patient, relatives, members of the MDT and other relevant health professionals regarding any changes in nutritional care plan such as introducing transitional feeding, change of feeding routes, or removal of feeding tube.

Survivorship/ Living with cancer/ Follow-up	• Provide on-going nutritional support to patients who remain dependent on enteral feeding systems • Provide on-going support to patients on oral nutrition support. • Frequency of follow up and length of dietetic care spell is dependent upon patient needs. Dietetic teams involved will vary dependant on local service.

Palliative Care/ End of Life	• Review treatment goals with the members of the MDT, the palliative care team, and with the patient. • Refer to Specialist Palliative Care Dietitian (if available in service) if and when required. • Liaise with community teams and hospice staff if required. **Follow the agreed Palliative Care (End of Life) Pathway or Specialist Palliative Care Pathway as appropriate**

For information

Nutritional Care Plan may include

- Texture modified diets of liquid, pureed or soft (National descriptors A - E).
- Standard high calorie, high protein interventions.
- Commencement of nutritional supplement drinks.
- Artificial enteral feeds via nasogastric, oesophogastric, gastrostomy or jejunostomy tubes.
- Fluid goals for hydration.
- Balancing above to ensure adequate nutritional status.
- Liaising with the home feeding company and other involved staff.

More detail on the nutritional management see the following chapter in the Head & Neck Cancer: United Kingdom National Multidisciplinary Guidelines (2016)

https://www.cambridge.org/core/services/aop-cambridge-core/content/view/A3A569F7731936A37C8FA6772E681AF7/S0022215116000402a.pdf/nutritional_management_in_head_and_neck_cancer_united_kingdom_national_multidisciplinary_guidelines.pdf