Centre for Sustainable Delivery

NHS SCOTLAND

Detect Cancer Earlier (DCE) Programme

Optimal Head and Neck Cancer Diagnostic Pathway

December 2023

Review date: December 2025

Background

In 2021, head and neck cancers were more than twice as common in the most deprived areas compared with the least deprived areas in Scotland[1]. Meanwhile, the incidence of late-stage diagnoses was more than three times higher in the most deprived areas compared with the least deprived[2].

Currently, around 25% of head and neck cancers are diagnosed at stage I in Scotland[3]. Latest cancer waiting times data (Q2 2023) also shows that 66.5% of head and neck cancer patients in Scotland were treated within the 62 day standard[4], reflecting current challenges in the diagnostic pathway.

This is partly why, in June 2023, Scotland's new Cancer Strategy for Scotland (2023-2033) and accompanying Cancer Action Plan for Scotland 2023 - 2026 included a commitment to enhance diagnostics and publish a national optimal diagnostic pathway for head and neck cancer.

Following this, the Centre for Sustainable Delivery's (CfSD) Cancer Performance and Earlier Diagnosis Team has worked closely with Regional Clinical Leads for Head and Neck Cancer, and engaged with Head and Neck Managed Clinical Networks to develop NHS Scotland's first Optimal Head and Neck Cancer Diagnostic Pathway.

Implementing best practice timed pathways supports the ongoing improvement effort to shorten pathways, reduce variation, improve patient experience of care, and meet existing cancer waiting times standards.

The pathway outlined in this document gives head and neck cancer service providers in NHS Scotland a gold standard skeleton model to deliver an effective and efficient head and neck diagnostic pathway. It sets timeframes for each step to enable diagnosis by day 30 and treatment to start by day 62.

Pathway recommendations

Week 1

An urgent suspicion of cancer (USC) GP or general dental practitioner (GDP) referral pathway should be used for patients who meet the Scottish Referral Guidelines (SRG) for Suspected Cancer criteria.

Primary care should inform the patient that they are being referred as USC at the point of referral, while reassuring them that the vast majority of referrals result in a non-cancer diagnosis.

Primary care should also make the patient aware of their responsibilities to make themselves available for tests and appointments in the coming days/weeks.

[1] https://publichealthscotland.scot/media/20142/2023-03-28-cancer-incidence-report_revised.pdf
[2] https://publichealthscotland.scot/media/20142/2023-03-28-cancer-incidence-report_revised.pdf
[3] https://publichealthscotland.scot/media/20142/2023-03-28-cancer-incidence-report_revised.pdf
[4] https://publichealthscotland.scot/media/22217/2023-09-26-cwt-report.pdf

Including as much relevant information and supporting materials in the initial referral from primary care is key to enabling active triage to ensure the patient is on the right pathway at the right time. Clinical triage can be done by a suitably experienced clinician – preferably by a consistent group, regularly – based on SRG guidance.

Risk-calculator tools are widely embedded in head and neck diagnostic pathways across the UK, including Scotland, with emerging evidence supporting their role in risk-stratifying at the front-end of the pathway. Available tools should be considered alongside the Principles of Realistic Medicine.

If a USC referral is regraded at the point of vetting, the USC National Regrading Guidance should be adopted with the initial referrer and patient informed.

Week 2

The first diagnostic test should happen within 7 days following vetting.

Coordinating and bundling diagnostic tests where possible can help reduce the number of times a patient needs to visit the hospital. This could be supported through the establishment of a diagnostic hub but alternative models are available for Boards with a smaller number of patients moving through the Head and Neck Pathway.

The aim is to physically ‘see’ the possible cancer via flexible endoscopy, imaging or biopsies to help confirm or rule out cancer.

Where possible, a navigator should be identified to provide consistent contact, build trust, and generally support the patient throughout the diagnostic pathway.

Patients should be informed about cancer being ruled out, or diagnosed, via the preferred method of communication agreed with the patient – this could be face-to-face or via telephone/virtual.

In cases where cancer is likely, the patients should meet the Clinical Nurse Specialist and be considered for a prehab referral. In cases where cancer is excluded, USC patients can be removed from tracking on a 62 day pathway.

Weeks 3-4

Standard imaging protocols should be applied for all Computed Tomography (CT), Magnetic Resonance Imaging (MRI), ultrasound and Positron Emission Tomography Computed Tomography (PET-CT). These should comply with Royal College of Radiologists recommendations or equivalent.

Where CT/MRI is appropriate, reporting should be completed in 4 days.

PET-CT should be carried out and reported within 10 calendar days, to allow preparation for treatment planning discussion by day 40.

Reports for tissue sampling should be available by day 26.

All histopathology should have a clear indicator, clarifying the urgency and date that the report is required by to ensure that the timescales for reporting is not lost between different clinicians or teams.

Weeks 5-6

Multidisciplinary team meeting (MDT)

The multidisciplinary team (MDT) meeting is the culmination of patient examinations/consultations and diagnostic investigations. Most MDT meetings take place on a weekly basis, usually on the same day each week and can be local (discussing patients from within one NHS Board), or regional (discussing patients from more than one Board within a region).

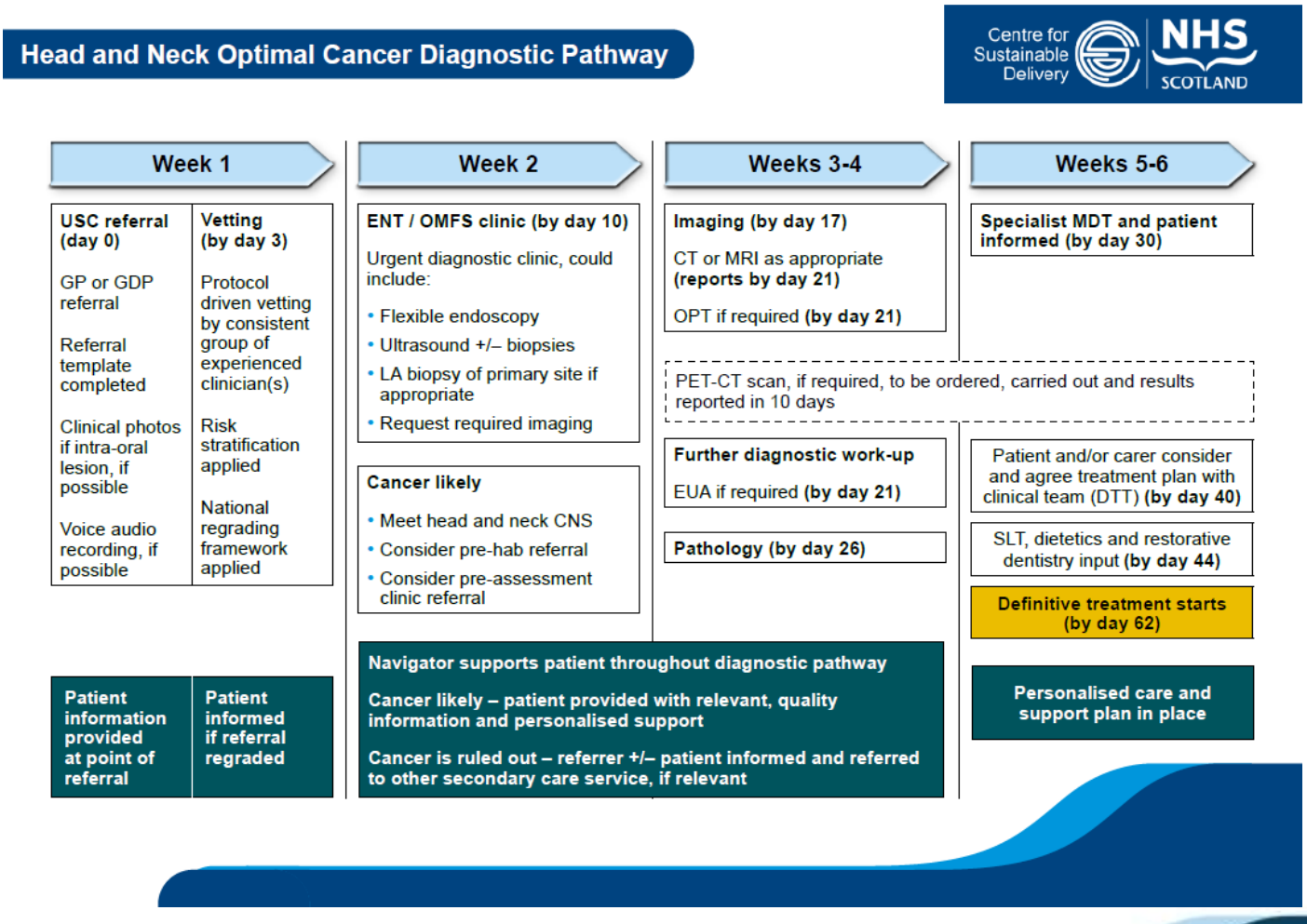
The MDT provides a professional forum to discuss patients' results and explore and agree the most effective treatment options available. It is crucial that all MDTs are coordinated and managed effectively to ensure there's clinical agreement on the next step of the patient's pathway and a decision to treat is not delayed. Recommendations on delivering Effective MDTs can be found in the Framework for Effective Cancer Management.

Holistic Needs Assessment (HNA)

Personalised care and support planning should be based on the patient and clinician(s) completing a holistic needs assessment shortly after diagnosis.

The HNA ensures conversations focus on what matters to the patient and considers wider health, wellbeing and practical support required. This helps enable shared decision-making regarding treatment and options.

Pathway summary diagram



References and further resources

- Scottish Referral Guidelines for Suspected Cancer – Head and Neck
  https://www.cancerreferral.scot.nhs.uk/head-and-neck-cancers/?alttemplate=Guideline

- Urgent Suspicion of Cancer – National Regrading Guidance
  https://www.gov.scot/publications/urgent-suspicion-cancer-national-regrading-guidance/

- Framework for Effective Cancer Management
  https://www.gov.scot/publications/framework-effective-cancer-management/

- A toolkit is available in the Cancer Repository of Good Practice on Turas to support NHS Teams with implementing Scotland's head and neck optimal cancer diagnostic pathway.

gjnh.cfsdpmo@gjnh.scot.nhs.uk

www.nhscfsd.co.uk

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