NHS England

Greater Manchester, Lancashire and South Cumbria
Strategic Clinical Network & Senate

Rehabilitation Care Pathway for Head & Neck Tumour

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CONTENTS

Introduction

This care pathway has been designed and agreed by the specialist AHPs working in the field of Head and Neck Cancer in Greater Manchester and Cheshire Cancer Network and by the Head and Neck clinical sub-group. It is one of a series of rehabilitation pathways that will be designed in 2010/11 to cover all major cancer specialties. It has been prepared in response to increasing demand for transparent and joined up pathways which facilitate responsive and efficient services for patients. It is based on the National Cancer Action Team Rehabilitation Care Pathways (2010)

Although relatively rare, head and neck cancer can have a profound effect of people's lives because of significant changes to lifestyle, function and image. The pathway provides guidance for rehabilitation specialists working with people with head and neck cancers and includes service configuration, the main referral criteria at each stage and links to service directories for the GMCCN rehab services and also those in adjacent areas where treatments cross network boundaries.

Professions involved

The rehabilitation care pathways focus on the needs of patients who require services provided by speech and language therapists, dieticians, physiotherapists, occupational therapists and lymphoedema practitioners.
The authors recognise the valuable role of maxillofacial prosthetics in the rehabilitation of this patient group which is outside of the scope of this specific document. If you would like to refer a patient for maxillofacial rehabilitation or would like further information please contact Carol Winter at carol.winter@uhsm.nhs.uk

Core MDT members

The Improving Outcomes in Head and Neck Cancers (2004) recommends that each Head and Neck MDT includes a speech and language therapist and a dietitian as core members of the multi-disciplinary team.
Physiotherapists and occupational therapists are recommended extended team members for Head & Neck MDT. There a no recommended AHP core members of the Thyroid MDT

Clinical sub-group

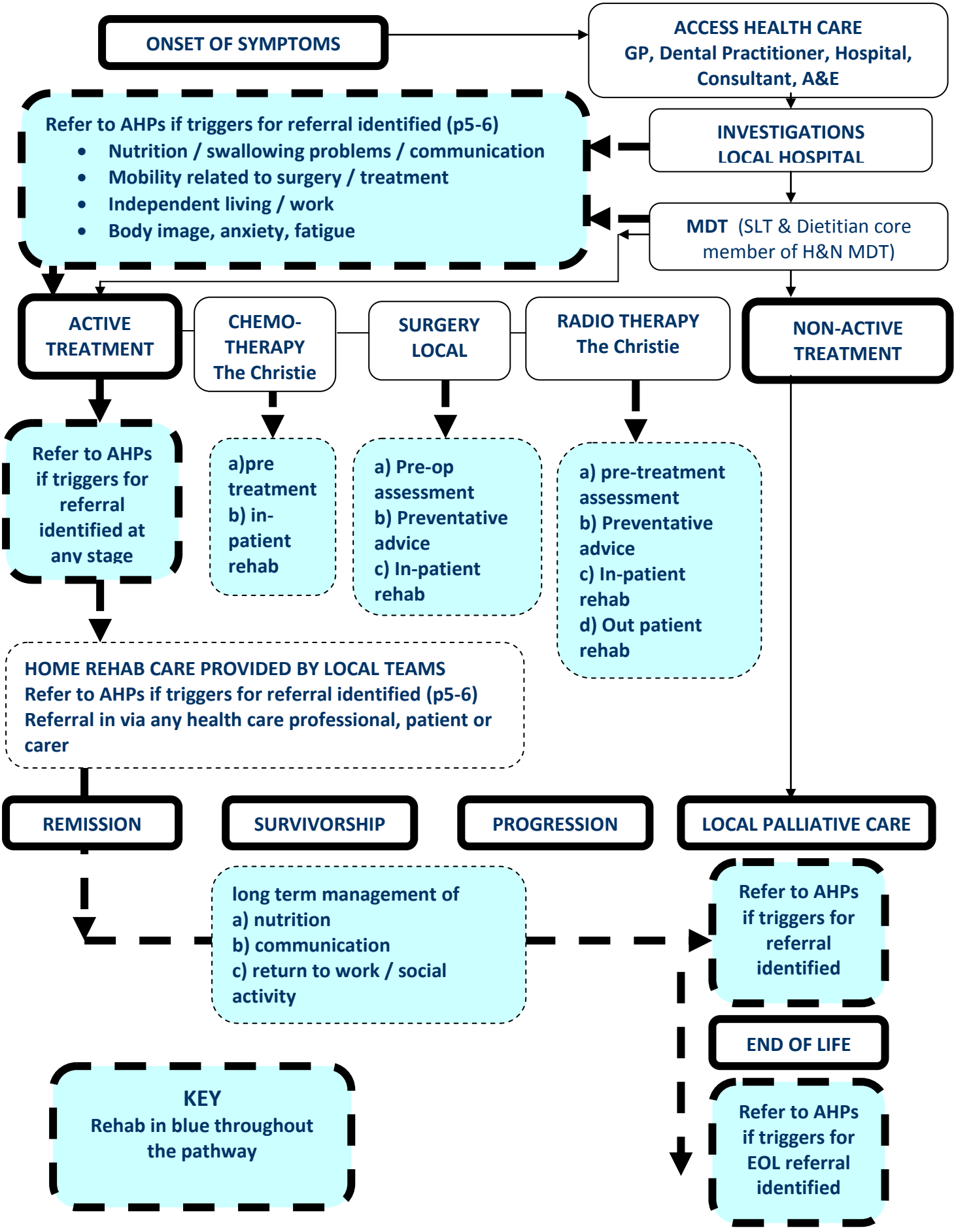
The network clinical sub-group membership includes two speech and language therapists and the AHP lead for the network. Meeting notes are available on the network website.

Service Configuration

There are 3 specialist head and neck MDTs Pennine, South Manchester and Central Manchester. South and Central meet at the Christie hospital followed by the MDT

clinic. Surgical sites are South Manchester University Hospital (South) and Manchester Royal infirmary (Central) and Pennine.
Services also cross network borders with referrals from North Derbyshire, Aintree and Blackburn. In addition there is a Thyroid MDYT which meets every 2 weeks at the Christie Hospital. The complexity of the configuration can be seen at appendix 1.

Head & Neck tumour rehabilitation pathway



Clinical Indicators for Referral to Rehabilitation Services

The following statements provide clinical indications for referrals to rehabilitation services at all stages of care.

The first diagram shows the universal referral triggers to AHPs for patients with a tumour diagnosis.
It also explains the role of AHPs in managing anxiety, body-image, fatigue, pain etc.

The second diagram shows the specific referral triggers for patients with a head & neck tumour diagnosis.

Universal referral triggers to AHPs for all tumour rehabilitation pathway

Nutrition & dietetics	Lymphoedema practitioner	Occupational Therapist	Physiotherapist	Speech & Language Therapist
Triggers a referral on nutritional screening tool Unintentional weight loss greater than 10% in the last 3-6 months. BMI 18.5 or less Difficulty swallowing Feeding tube needed Treatment side effects affecting appetite or swallowing	Longstanding oedema > 3 months, not relieved by elevation Fullness, tightness or heaviness in the limb Aching Observable swelling and / or palpable tissue changes Clothing or jewellery become tighter e.g. ring, sleeve, watch, shoe	Altered mobility affecting daily function Altered mood, anxiety and body image affecting daily living Fatigue impacting on activity Needs equipment / wheelchair / seating to promote independence Changes to memory, personality, cognition, perception that affect ability to function independently.	Altered mobility, tone, power, balance and range of movement Altered respiratory function Pain related to altered mobility Post surgical scarring in tissues Fatigue when mobilising	Slurred speech Difficulty understanding or using spoken or written language Communication impacting on life, work, relationships Altered voice (husky, weak, harsh) Difficulty swallowing food or fluids Recurrent chest infections Wet voice

AHP role in symptom management when related to specific rehabilitation need

Anxiety	Related to e.g. swallowing problem (SLT or N&D), loss of role (OT), fear of mobilising (PT), managing trache / stoma (PT, SLT)
Fatigue	related to e.g. nutrition, loss of mobility, power or altered tone, side effect of treatment
Breathlessness	related to e.g. mobility, activities of daily living or during / after eating
Pain	related to symptoms above e.g. altered tone, lymphoedema that will respond to compression garment and/or bandaging, benefit from mobilisation, splinting, TENS, specialist seating etc
Body image & sexuality	related to symptoms and treatment e.g. hemiplegia, facial surgery, weight loss / gain
Return to work	where rehabilitation can support this e.g. portable feeding equipment, appropriate mobility aid and workplace assessment, communication aid / advice

Referral Triggers to AHPs for head & neck tumour rehabilitation pathway

Nutrition & dietetics	Lymphoedema practitioner	Occupational Therapist	Physiotherapist	Speech & Language Therapist
PRE DIAGNOSIS Meets the trigger for referral on a nutritional screening tool. Lost 5-10% or more of their body weight in the last 3 to 6 months BMI 20-18.5 or less Difficulty swallowing foods DIAGNOSIS as above plus: Will be having radical radiotherapy +/- chemotherapy, surgery or combined treatment. Has oropharyngeal / nasopharyngeal /hypopharyngeal / advanced laryngeal / oral cavity tumour stage T3/4 TREATMENT as above plus mucositis MONITORING & SURVIVORSHIP Requires a feeding tube or has one in place Long term effects of treatment affecting swallowing New difficulty swallowing PALLIATIVE as above END OF LIFE as above plus Requires removal of feeding tube. Relatives have concerns re nutrition	PRE DIAGNOSIS Facial oedema DIAGNOSIS Planned treatment may cause lymphoedema. Advise patient as part of consent to treatment process and advise on preventing lymphoedema. TREATMENT as above plus Posture advice Neck, shoulder and jaw exercises Head and neck oedema causing respiratory / psychological effect and limitation of movement. MONITORING & SURVIVORSHIP As above plus Develops cellulitis leading to head and neck oedema PALLIATIVE and END OF LIFE as above plus Has developed lymphorroea Requires palliation of symptoms	PRE DIAGNOSIS & DIAGNOSIS Poor functional capability Lives alone TREATMENT Loss of function / independence during treatment Fatigue Not engaging in activities of daily living because of anxiety, depression or altered body image Quality of life affected by spirituality, sleeplessness or anxiety MONITORING AND SURVOVORSHIP as above plus Needs further advice to get back to work Shows signs of withdrawal PALLIATIVE CARE & END OF LIFE as above plus Difficulty with transfers, manual handling, managing home environment, personal care or functional mobility Carer having difficulty managing loss of function / mobility / independence	PRE DIAGNOSIS Pre-existing chest complaint Difficulty mobilising Generally debilitated or history of falls Reduced motor power DIAGNOSIS as above plus Restricted range of movement at the neck / shoulder / jaw restricting function TREATMENT as above plus Having bilateral neck node removal Removal of neck nodes with risk of lymphoedema Develops respiratory complications during surgery or radiotherapy Tracheostomy care New facial palsy Pain secondary to cancer treatment impacting on mobility and function MONITORING & SURVIVORSHIP as above plus Tissue tightness restricting movement of head & neck. Exercise programme would be of benefit Oedema or lymphoedema having a respiratory or psychological effect Living downstairs due to reduced mobility, muscle strength or shortness of breath PALLIATIVE as above plus needs a cervical collar for pain / posture END OF LIFE as above plus has difficulty clearing secretions requiring active treatment.	PRE DIAGNOSIS & DIAGNOSIS Dysphagia signs; change in swallow, pain, discomfort, coughing, throat clearing after eating / drinking. Altered voice; weak, breathy, harsh, hoarse, gurgly. Difficulty communicating TREATMENT as above plus taking longer to eat, eating less, avoiding specific foods, prevention of trismus during XRT MONITORING & SURVIVORSHIP as above plus increased pain / discomfort, weight loss PALLIATIVE or END OF LIFE Difficulty communicating and / or swallowing. Is nil by mouth and wishes to eat

Communicating across services

- Links to the Greater Manchester and Cheshire Cancer Network Rehabilitation Directory

Contact details for rehabilitation services across the network area are available via the directory which is published on the network website.
Cancer & Palliative Care Rehabilitation Services Directory
http://www.gmccn.nhs.uk/hp/Resources/NetworkCancerServicesDirectory/CancerRehabilitationServices

- Links to directories in adjacent cancer networks

Those in adjacent network areas – North Trent, Lancashire and South Cumbria - are also available to facilitate referral to appropriate services in other localities.

National Cancer Action Team Rehabilitation Care Pathways

The National Cancer Action Team Rehabilitation Care Pathways are available via the following website. References for supporting literature are also available on the same website.
http://www.cancer.nhs.uk/rehabilitation/rehab_pathways.html

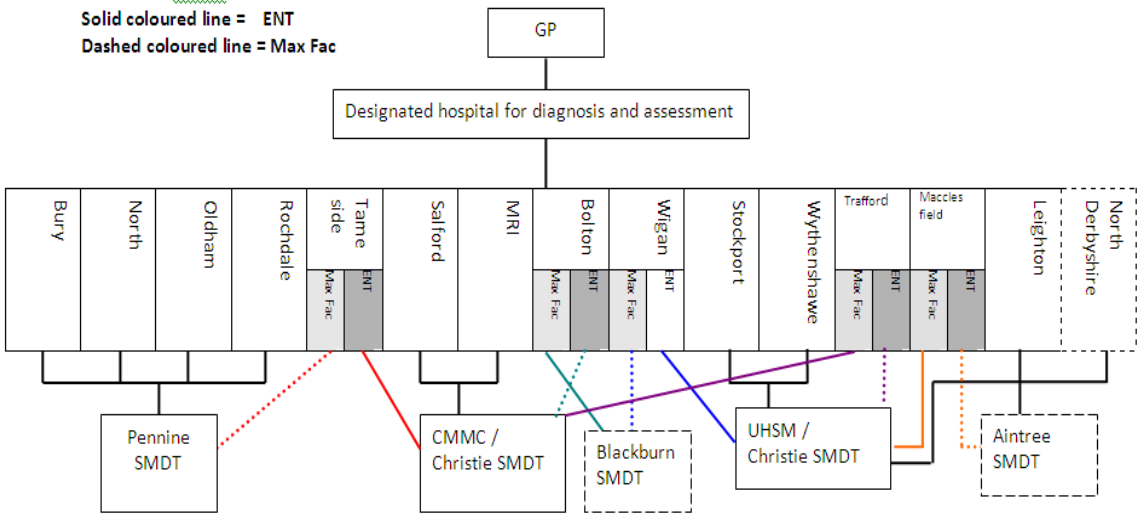
References

- Improving Outcomes Guidance in Head & Neck Cancer (2004)
- National Cancer Action Team (2010) Rehabilitation Care Pathways
- RCSLT. (2010) Resource manual for commissioning and planning services for SLCN Head & Neck Cancer

Appendix 1: Head & Neck cancer service configuration GMCCN

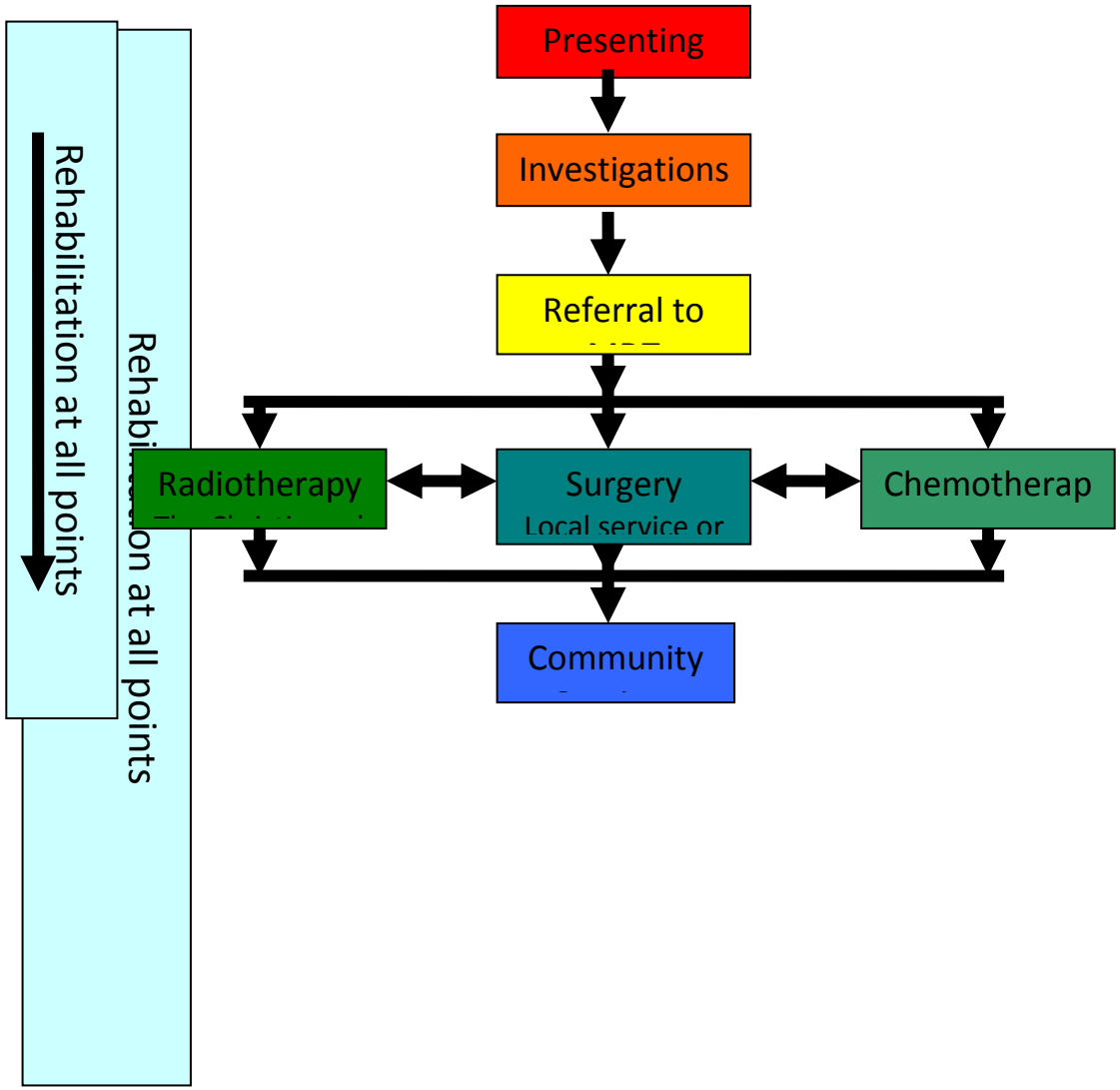
KEY:

Solid black line = Max Fac and ENT
Solid coloured line = ENT
Dashed coloured line = Max Fac



Appendix 2 Head & Neck Service configuration GMCCN

Greater Manchester & Cheshire Cancer Network



Appendix 3 Contributors

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