Patient and Public Summary of the National Head and Neck Cancer Audit (NaHaNCA) Feasibility Study Interim Report

How care is delivered and the feasibility of introducing a national audit for adults with head and neck cancer in England

Released May 2026

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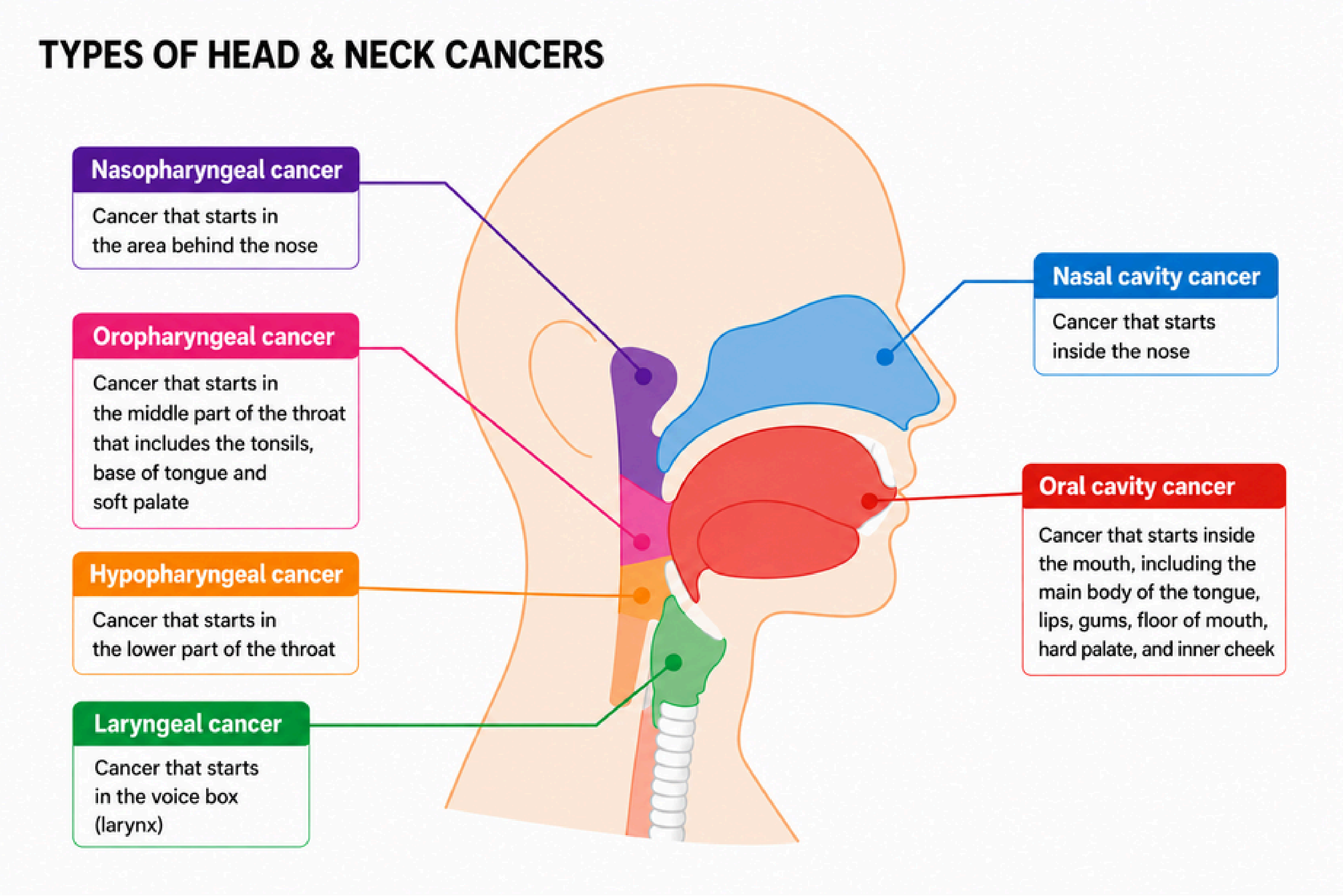
About Summary

This report summarises the progress of the ongoing **National Head and Neck Cancer Audit (NaHaNCA) Feasibility Study**.

The study looks at whether a future national audit for head and neck cancer in England can be built using routinely collected NHS data, rather than extra manual data collection, and it focuses on **squamous cancers (a cancer of the surface cells of the body)** of the three most common sites: **larynx (throat), oral cavity (mouth), and oropharynx (tonsils, base of tongue, soft palate),** which includes approximately 90% of all head and neck cancers.

Other sites, such as the salivary glands, nose, and other rare cancer types, are not yet included in the current report, but there is a longer-term ambition to expand the audit to cover these once feasibility is established for the more common sites. Information about these less common cancers is expected to be included in a second patient summary, planned for release in March 2027.



In this report, we describe how the study developed a set of measurable, useful performance indicators for a future audit and presents early findings on **incidence, stage at diagnosis, cancer waiting times, and overall survival.** The report uses linked national datasets to understand how patients are cared for, what their outcomes are, and where there are differences or inequalities. It also points out where important information is still missing, such as details about certain parts of patient care and their quality of life.

This report is intended to help patients, families, carers, and the public understand what the interim report set out to do, what it found so far, and why a national audit could help make head and neck cancer care in England better, fairer and more consistent.

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Why is this study important?

Head and neck cancer affects around 12,500 people each year in the UK. Primary treatment can involve surgery, radiotherapy, chemotherapy, or a combination of these. These treatments can affect speech, swallowing, breathing, appearance and quality of life.

There are already national audits for some cancers, such as prostate cancer. Since it started in 2013, the National Prostate Cancer Audit (NPCA) has used NHS data to monitor how men are diagnosed and treated, and how well they recover. It has helped reduce unnecessary treatment for patients with low-risk cancer and made sure that those with higher-risk cancer receive appropriate treatment. It has also highlighted differences in care between hospitals and groups of patients, helping services improve and become more consistent.

At the moment, there is no national clinical audit for head and neck cancer in England. A national audit would help check whether patients are receiving the right care quickly enough, and whether care and outcomes differ between areas of the country or between hospitals. Audit also help us set standards and identify where standards aren’t met, so that corrective measures can be set in place.

Why does this matter for patients?

A national audit can:

- Show where care is working well.
- Highlight where improvements are needed.
- Reduce unfair differences in care.
- Support better outcomes and experiences for patients.

This study is the first step towards developing an ongoing, national head and neck cancer audit in England.

What did we do?

We used existing national cancer registration data and linked NHS datasets to:

- Develop a set of important performance indicators (measures of care quality)
- Describe national patterns of diagnosis, treatment and survival.
- Explore whether care and outcomes vary across regions or hospitals.

We included over 52,000 adults diagnosed with cancers of the larynx (voice box), oral cavity (mouth) or oropharynx (throat) between 2014 and 2020, which was the latest data available. The eligible patients were identified from the English National Cancer Registration Dataset (NCRD), the data access was funded through a National Institute for Health and Care Research (NIHR) research grant. At the start of the programme in April 2022, only data up to 2020 were available to us.

For some results, we also broke them down into two patient groups based on the primary treatment type:

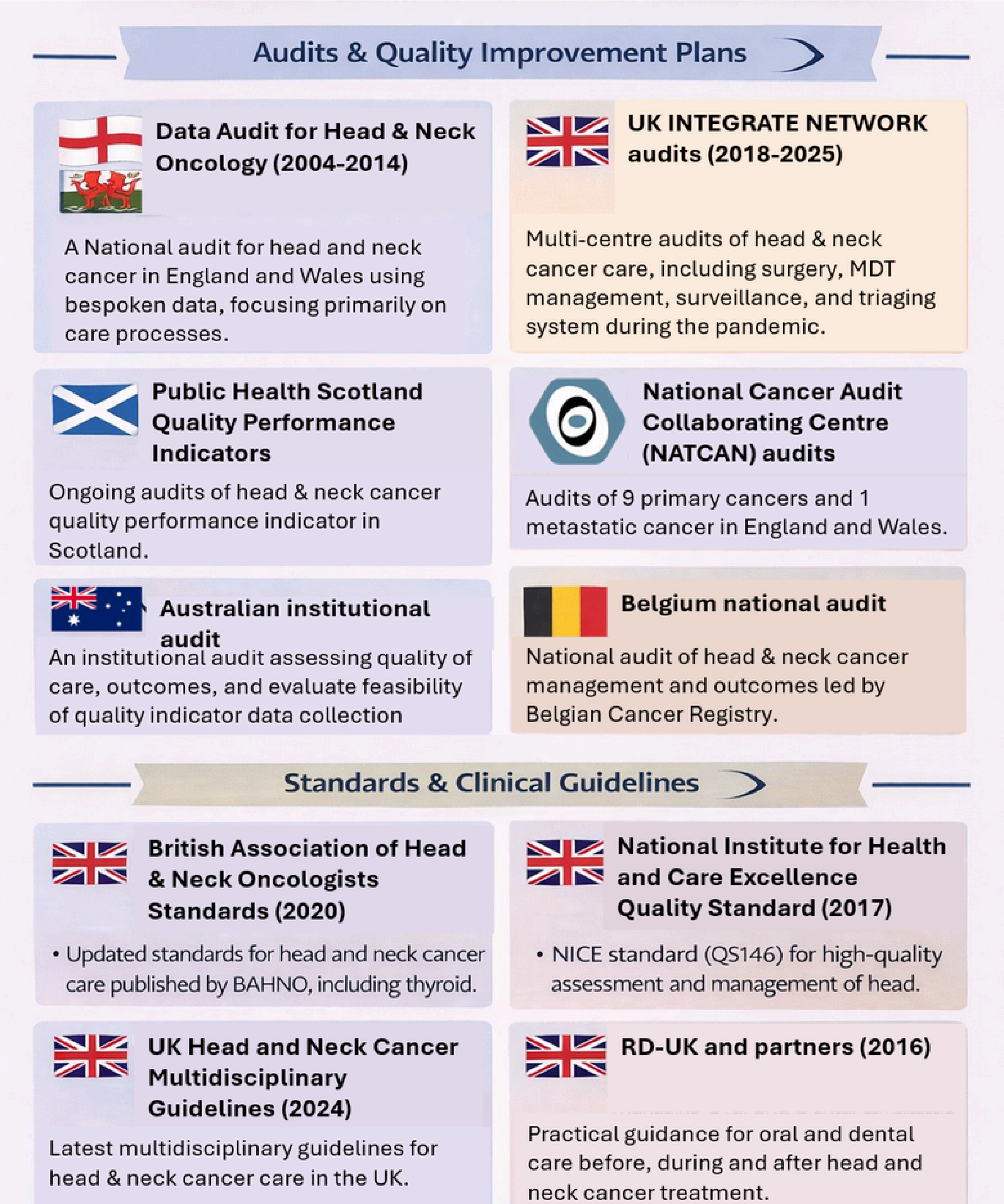
- **Surgery group:** patients who were treated with surgery as their first primary treatment.
- **Oncology group:** patients who were treated with radiotherapy or chemoradiotherapy as their first primary treatment.

How we chose the measures for the study

A national audit needs clear and useful measures to check whether care is safe, given on time and works well. These measures are called **Performance Indicators**.

To choose the right performance indicators for the NaHaNCA feasibility study, we used a careful and open process as below.

Step 1: Reviewing standards and audits.
We started by reviewing previous UK head and neck cancer audits, national guidelines, other national cancer audits in England, and international audits. This review identified **165 possible measures** covering diagnosis, treatment, follow-up and outcomes.



Audits & Quality Improvement Plans

Data Audit for Head & Neck Oncology (2004-2014)

A National audit for head and neck cancer in England and Wales using bespoken data, focusing primarily on care processes.

UK INTEGRATE NETWORK audits (2018-2025)

Multi-centre audits of head & neck cancer care, including surgery, MDT management, surveillance, and triaging system during the pandemic.

Public Health Scotland Quality Performance Indicators

Ongoing audits of head & neck cancer quality performance indicator in Scotland.

National Cancer Audit Collaborating Centre (NATCAN) audits

Audits of 9 primary cancers and 1 metastatic cancer in England and Wales.

Australian institutional audit

An institutional audit assessing quality of care, outcomes, and evaluate feasibility of quality indicator data collection

Belgium national audit

National audit of head & neck cancer management and outcomes led by Belgian Cancer Registry.

Standards & Clinical Guidelines

British Association of Head & Neck Oncologists Standards (2020)

- Updated standards for head and neck cancer care published by BAHNO, including thyroid.

National Institute for Health and Care Excellence Quality Standard (2017)

- NICE standard (QS146) for high-quality assessment and management of head.

UK Head and Neck Cancer Multidisciplinary Guidelines (2024)

Latest multidisciplinary guidelines for head & neck cancer care in the UK.

RD-UK and partners (2016)

Practical guidance for oral and dental care before, during and after head and neck cancer treatment.

Step 2: Making sure indicators can be measured in national data.
The national datasets we use are described below:

Data We Use in Our Cancer Research

Gold Standard Cancer Data

Updated yearly with details of diagnosis, treatment and outcomes

Rapid Cancer Data

Updated every 3 months, faster but less detailed

Hospital Records

Admissions, appointments & A&E visits

Chemotherapy Data

Drugs & treatment details

Radiotherapy Data

Radiation treatment info

Cancer Waiting Times

Waiting times for cancer care

Imaging Data

X-rays & scans information

Prescription Data

Medicines from your GP

Patient Experience Survey

Your feedback on care

Survival Data

Causes & location of deaths

We combine these data sources to understand cancer care.

Because not all data is consistently complete, up to date, or recorded in a way that allows for reliable measurement, the research team worked out which indicators could be measured accurately using the existing datasets.

For each indicator, we assessed:

- Data availability: whether the data items needed were recorded within national datasets.
- Completeness: how many patients had the required information recorded.
- Consistency: whether data items were recorded in the same way across NHS hospitals and over time.
- Validity: whether the data items accurately measured what they set out to (e.g., whether procedure codes can be used to work out which surgical treatment a patient had).
- Case-mix adjustment: whether enough information was available to measure differences between hospitals in patients and their cancer (e.g., age, stage, other serious illnesses and cancer site) to be able to make fair comparisons.
- Reliability: whether there were enough patients and events to be able to measure the performance indicator accurately in each region or hospital.

There were some important performance indicators that cannot yet be accurately measured in national routine data (e.g., patient-reported outcomes are not yet nationally collected and Multidisciplinary team meeting data is very incomplete).

Of the 165 possible indicators, **32 indicators** were **measurable indicators** and were taken forward to the next stages.

Step 3a: Working with clinicians to assess what can be acted on.

A Study Steering Committee (SSC) was set up before the study began. The SSC included 14 clinical experts involved in head and neck cancer care, including surgeons, oncologists, Speech and Language Therapists, a restorative dentist, a radiologist, a trainee doctor, and three patient and public representatives. This helped to make sure that performance indicators chosen are the most important for clinical practice and patients.

From the list of all possible indicators, the SSC clinician members were asked in a survey:

- Does this indicator measure something that truly matters for patient care, safety, or outcomes?
- Can NHS hospitals influence and improve this indicator?

After this in a meeting the SSC clinicians decided an indicator was actionable if

- Hospitals can directly influence it through clinical decisions or service organisation.
- It reflects processes that can be improved through better coordination, communication, staffing, or pathway redesign.
- It can be meaningfully monitored at hospital level and used to support quality improvement.

For example, cancer waiting times were considered highly actionable because hospitals can improve how quickly patients get seen in hospital after referral and make sure they get their diagnostic tests on time. Some indicators, such as risk factors for head and neck cancer or social factors, were agreed to be important but are difficult for hospitals to change. Only indicators that a hospital can have an impact on were chosen as important for a national clinical audit aiming to improve hospital care.

The SSC clinician members discussed each indicator carefully, also considering fairness (for example, whether case-mix adjustment would be needed to compare hospitals), and whether there was a risk of unintended consequences (for example, hospitals or clinicians might prefer to operate on patients who are fitter and have fewer health conditions to meet the target of reducing deaths within 30 days after surgery). Through structured discussion and scoring, the list was refined to identify those indicators that were both clinically meaningful and realistically improvable. This process ensured that the final high-priority indicators are practical tools for driving measurable improvements in NHS head and neck cancer services.

Step 3b: Working with the Head and Neck Cancer Coalition UK to assess what can be acted on.

To ensure the audit focuses on what matters to people affected by head and neck cancer, we worked with three representatives (BF, SP and MB) from the Head and Neck Cancer Coalition UK, which brings together 16 organisations, including patient groups, to provide a collective community perspective—two of whom have lived experience of head and neck cancer.Two meetings were held, supported by research team members (JS and KW) who explained the indicators in clear, non-technical language.

Patient advisers were given a shortlist of indicators with explanations of what each measure meant and examples of how results might be reported. They were then asked to consider three key questions:

- Is this important to patients?
- Would improving this make a meaningful difference to patient experience or outcomes?
- Is this something NHS services could realistically improve (i.e., is it actionable)?

During the workshops, patient representatives ranked indicators as high, medium or low priority. They also discussed which indicators would matter most to them by sharing lived experiences. They pointed out gaps in the indicators, especially around rehabilitation and quality of life. Their feedback helped to make sure that the study includes indicators on how quickly patients get treated, rehabilitation and care from all important specialists. They also explained how important it is that care and outcomes are fair across regions, hospitals and different groups of patients.

Step 4: Getting more opinions from across the country.
To make sure the audit reflects views from across the country, not just those involved in the SSC, we asked the opinions of lots of different specialists in head and neck cancer care.

We shared the suggested performance indicators at the 2025 Annual Scientific Meeting of the British Association of Head & Neck Oncologists (BAHNO). This meeting includes surgeons, oncologists, speech and language therapists, nurses, allied health professionals, researchers and other specialists involved in head and neck cancer care.

After the presentation, we emailed all members of BAHNO asking them to fill in an online survey. The survey asked people to choose the five indicators out of 32 measurable indicators that they felt were most important and actionable. They were also asked to comment on whether the indicators were clearly described and possible to measure, let us know about any missing areas of care.

Nearly 100 surveys were filled in by surgeons, oncologists, speech and language therapists, clinical nurse specialists, allied health professionals, and patient/public representatives.

Step 5: Final choice of indicators for the study
We brought together feedback from SSC clinician members, the patient representatives, and the national survey. Indicators were only chosen if they were:

- Important to patients,
- Supported by clinicians, and
- Measurable using existing national data.

We chose **8 high-priority indicators**. Together, they cover how quickly patients are treated, whether cancers are found early, the quality and safety of care, how people do in the long-term after treatment, and the support and rehabilitation they are given.

8 Key Indicators for the Head and Neck Cancer Audit Feasibility Study

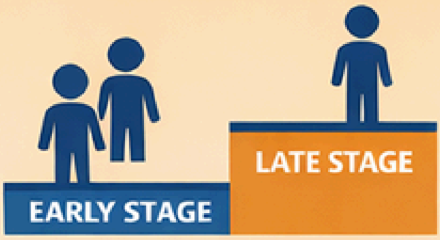
TREATMENT WITHIN 62 DAYS

Patients starting treatment within 62 days of urgent referral.

INCIDENCE OF HNC

Number of new head and neck cancer cases diagnosed.

STAGE AT DIAGNOSIS



Percentage diagnosed at early vs. late stage.

USE OF CURATIVE TREATMENT

Patients receiving treatment aimed at curing the cancer.

EARLY MORTALITY

Deaths within 30 or 90 days of treatment.

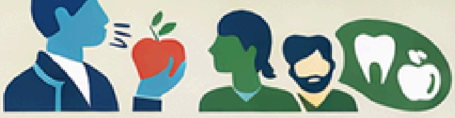
CANCER RECURRENCE

Patients with cancer returning within 5 years.

SURVIVAL WITHIN 5 YEARS

Patients surviving within 5 years of diagnosis.

ACCESS TO REHABILITATION AND SUPPORTIVE CARE



Patients receiving care from Allied Health Professionals during follow up.

— MONITORING DIAGNOSIS, TREATMENT, OUTCOMES & SUPPORT —

What did we find so far?

1. Incidence: how common head and neck cancer is

1.1 What are “incidence” and “stage”?

Incidence means the number of new cases diagnosed in a population over a period of time. In this report, incidence is shown as the number of cases per year per 100,000 people.

Cancer stage describes how far the cancer has grown or spread at the time of diagnosis. In this report, stages were grouped as:

- Stage 1–2: earlier-stage cancer
- Stage 3–4: more advanced cancer

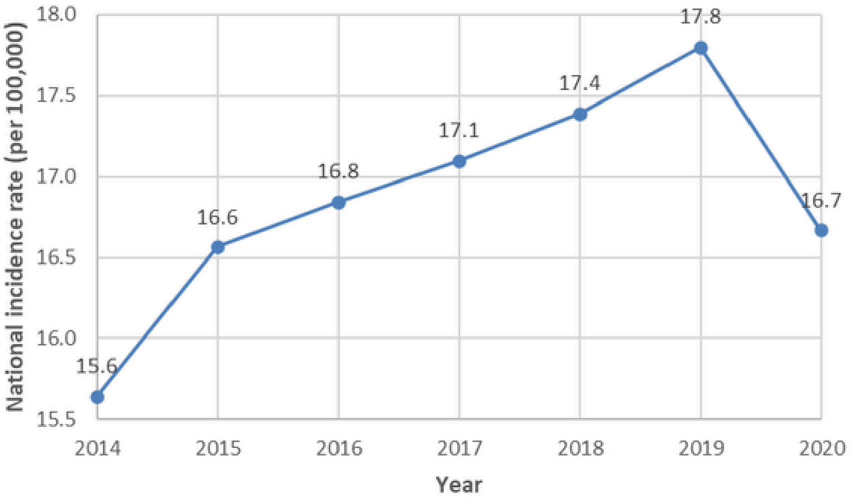
The report also looked at T, N, and M stages:

- T stage describes the size of the cancer
- N stage describes spread to nearby lymph nodes
- M stage describes spread to other parts of the body

1.2 National picture

Between 2014 and 2020, the national incidence of head and neck cancer in England was **16.86 per 100,000 people**. The incidence of **stage 3–4 cancer** alone was **10.69 per 100,000.** This means that not only was head and neck cancer fairly common overall, but a large share of cases were already advanced by the time they were diagnosed.

Between 2014 and 2019, the number of people diagnosed with this cancer increased, from **15.6 to 17.8 per 100,000 people. In 2020**, there was a drop in diagnoses. This was likely due to temporary changes in how the NHS worked during the COVID-19 pandemic. During this time, patients were prioritised based on how urgent their symptoms were, rather than following the usual process. Many first appointments took place by phone or video instead of in person. Referrals for suspected cancer were also checked more strictly. Some tests, such as scans, endoscopies, and biopsies, were delayed or limited because of infection control measures and staff being redeployed to other services. As a result, people with less clear or lower-risk symptoms were more likely to have their care delayed rather than receiving an immediate diagnosis.



When looking at each type of cancer separately, cancers of the **oropharynx were the most common**, with 7.1 cases per 100,000 people. This was **followed by cancers of the oral cavity**, with 5.8 cases per 100,000 people, and **cancers of the larynx**, with 4.0 cases per 100,000 people.

1.3 Differences between Cancer Alliances

The report found that the number of cases varied depending on the region. These regions are organised into Cancer Alliances—groups of NHS organisations that work together locally to plan and deliver cancer care. Even after taking account of age, sex, ethnicity, deprivation, and year of diagnosis, some areas still had higher rates than others.

For overall head and neck cancer incidence, the highest adjusted rates (rates allowing for differences in patients' age, sex, ethnicity, deprivation of where they live, year of diagnosis, and the type of cancer) were seen in:

- Cheshire and Merseyside: 19.21 per 100,000
- Lancashire and South Cumbria: 18.53 per 100,000
- Greater Manchester: 18.25 per 100,000

The lowest adjusted rates were seen in:

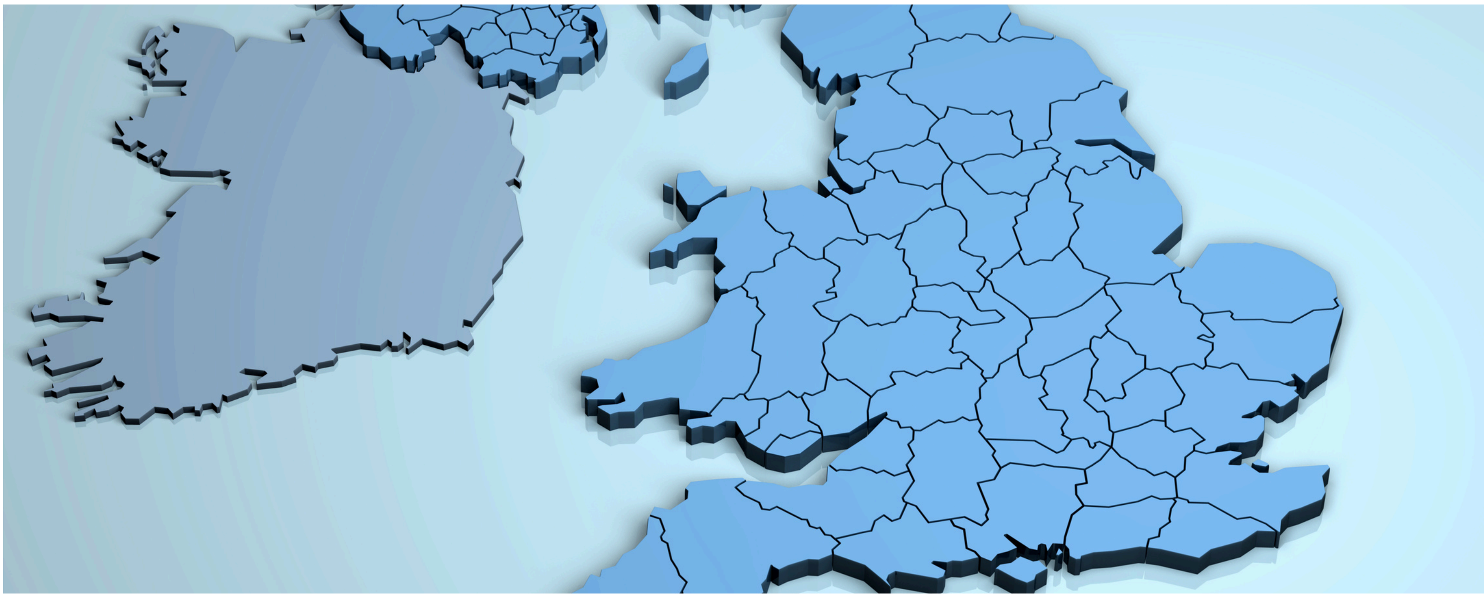
- Northeast London: 15.25 per 100,000
- North Central London: 15.42 per 100,000
- Kent and Medway: 15.56 per 100,000

For advanced cancers diagnosed at stage 3–4, the highest adjusted rates were reported in:

- Surrey and Sussex: 12.98 per 100,000
- Cheshire and Merseyside: 12.73 per 100,000
- Greater Manchester: 12.65 per 100,000

The lowest adjusted rates for stage 3–4 disease were seen in:

- East of England: 10.65 per 100,000
- Kent and Medway: 10.68 per 100,000
- Somerset, Wiltshire, Avon and Gloucestershire: 10.77 per 100,000



1.4 Who gets head and neck cancer?

Head and neck cancer is more common in older age groups, especially people aged 65–69. The report found clear inequalities in incidence. Head and neck cancer was also more common in:

- **men**
- **White populations**
- people living in the **most deprived areas.**

Compared with women, men had **more than 2 times** the chance of overall head and neck cancer and the chance of stage 3–4 cancer. People in the **least deprived** areas had much lower chance of cancer than those in the **most deprived** areas. For example, the least deprived group had 42% lower chance of any head and neck cancer, and 48% lower chance of stage 3-4 head and neck cancer. This was after accounting for age, sex, ethnicity and year.

What this means for patients and the public

These findings suggest that head and neck cancer is not spread evenly across the country and patient groups. This points to health inequalities, including difference by deprivation, ethnicity and sex. It also shows why prevention, awareness, early diagnosis, and support services may need to be targeted more strongly in higher-risk communities.

2. Diagnosis stage: how advanced cancer was found and when

2.1 National picture

Between 2014-2020, **63.4%** of all head and neck cancer patients were diagnosed with **stage 3–4 cancer**. This means that nearly two-thirds of patients were diagnosed after the disease had already become advanced.

Looking at the more detailed stage measures:

- **38.70%** had **T3–4** disease.
- **56.08%** had **N1–3** disease.
- **2.81%** had **M1** disease at diagnosis.

These figures show that advanced disease at diagnosis is common in head and neck cancer.

When looking at each type of cancer separately, cancers of the **oropharynx had the highest proportion of late-stage cancer**, with 42% of cases diagnosed with stage 3-4 cancer. This was **followed by cancers of the oral cavity** (34%) and **cancers of the larynx** (24%).

2.2 Differences between regions

The report found moderate geographic variation in the proportion of cancers diagnosed at stage 3–4. The regional variation remained after adjustment for age, sex, ethnicity, deprivation, and year of diagnosis. The highest adjusted proportions of stage 3–4 cancer were in:

- **West London**: 67.8%
- **Southeast London**: 67.0%
- **Surrey and Sussex**: 66.45%

The lowest adjusted proportions were in:

- **Somerset, Wiltshire, Avon and Gloucestershire**: 59.8%
- **Lancashire and South Cumbria**: 60.53%
- **Cheshire and Merseyside**: 61.51%

2.3 Who are diagnosed with stage 3-4 cancer?

The study also found differences between patient groups. People aged **50–64** were more likely to be diagnosed with stage 3–4 disease than those aged 18–49. Men were also slightly more likely than women to be diagnosed at an advanced stage.

People living in the least deprived areas were less likely to be diagnosed with advanced disease than those in the most deprived areas.

There was little difference by broad ethnic grouping (White and non-White) in this particular model.

What this means for patients and the public

The biggest message here is that **many people are being diagnosed late**. Earlier diagnosis often gives a better chance of successful treatment and may mean less intense treatment is needed. The fact that almost two-thirds of patients had stage 3-4 disease suggests that there is still a major need for:

- greater public awareness of symptoms
- early referral from pimary care
- being seen by the right specialist quickly
- work to reduce inequalities in deprived communities

3. Cancer waiting time: how long people waited to start treatment

3.1 Why waiting time matters?

Timely treatment is important in cancer care. Long waits can increase anxiety for patients and families, and delays may affect how patients do in the long-term. The NHS standard used in this report is the **62-day target**, which measures the time from urgent referral to first treatment.

3.2 Who was included?

This analysis included 30,506 patients diagnosed between **2014 and 2019** who were treated with the aim of curing them of cancer. Of these:

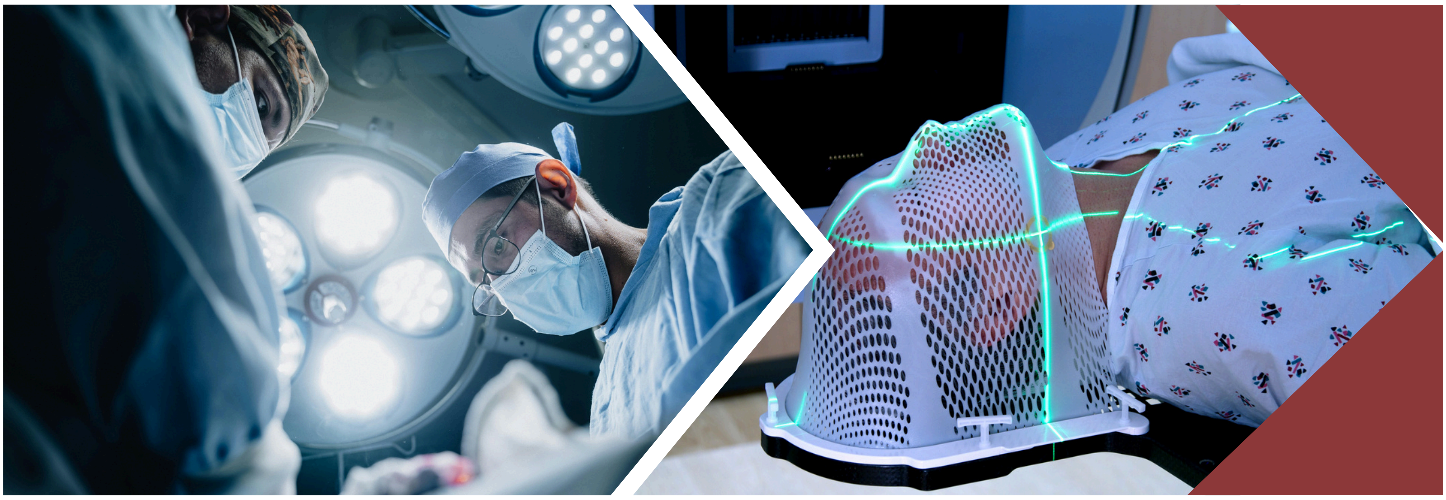
- **15,463 patients (51%)** were in the **surgery group**.
- **15,043 patients (49%)** were in the **oncology group**.

3.3 How many started treatments within 62 days?

The results showed a clear difference between treatment types.

- In the **surgery group, 68%** started treatment within 62 days.
- In the **oncology group,** only **48%** started treatment within 62 days.

This means that fewer than half of patients in the oncology group met the 62-day target.



3.4 Average waiting times

The average time from referral to treatment was:

- **53 days** for the surgery group
- **65 days** for the oncology group

So, the typical patient in the oncology group waited longer than the NHS target, while the typical patient in the surgery group started treatment just within it.

3.5 Long delays

The report also looked at very long delays of **90 days or more** from referral to starting treatment, which is at least four weeks beyond the 62-day target.

- **10%** of surgery patients had these long delays.
- **20%** of oncology patients had these long delays.

This means one in five patients in the oncology group experienced a major delay.

3.6 Where delays happened in the pathway?

The treatment pathway was divided into three parts:

1. referral to first specialist appointment
2. first specialist appointment to decision to treat.
3. decision to treat to treatment start.

For both groups, the longest part was **first seen to decision to treat:**

- **28 days** in the surgery group
- **32 days** in the oncology group

The biggest difference between the two groups was the time from **decision to treat to starting treatment**:

- 13 days for the surgery group
- 21 days for the oncology group

This suggests that delays were especially marked in getting oncology treatment started after the treatment decision had already been made.

3.7 Differences between Cancer Alliances

Using 2018–2019 data, the report found wide variation between Cancer Alliances in the percentage of patients treated within 62 days.

- In the **surgery group**, performance ranged from **56% to 82%**.
- In the **oncology group**, performance ranged from **27% to 73%**.

This shows that waiting times varied a lot across England, especially for oncology treatment.

What this means for patients and the public

These findings are important because they show that patients are not always treated on time, especially for patients having oncology treatment. The large differences between regions suggest that some delays may be avoidable and that better-performing services may offer useful lessons for others. For patients, this means that where you are treated and what kind of treatment you need may affect how long you wait.

4. Survival after diagnosis: what happened after treatment

4.1 What “overall survival” means?

Overall survival means the proportion of patients who are still alive after a certain length of time following diagnosis, no matter what the cause of death was. In this report, survival was mainly shown at **2 years** and **5 years** after diagnosis.

4.2 National survival rates

The national overall survival rates for head and neck cancer were:

- **69.7%** at **2 years**
- **56.1%** at **5 years**

So, about seven in ten patients were alive two years after diagnosis, and a little over half were alive five years after diagnosis.

4.3 Survival by cancer site

Survival differed depending on where the cancer started.

For **laryngeal cancer**, survival was:

- **70.1%** at 2 years
- **53.1%** at 5 years

For **oral cavity cancer**, survival was:

- **63.7%** at 2 years
- **50.9%** at 5 years

For **oropharyngeal cancer**, survival was:

- **74.3%** at 2 years
- **62.3%** at 5 years

This means, between 2014-2020, oropharyngeal cancer had the best survival of the three groups in this report, while oral cavity cancer had the lowest.

4.4 Differences between regions and hospitals

After accounting for patient and cancer factors, the report found **little differences in survival between regions**. However, it found **differences in survival between hospitals** where patients were diagnosed.

This suggests that survival looked similar between regional level, but there may be bigger differences when looking at individual hospitals. This does not tell us why the differences between hospitals exist, but it helps show where we may need to look more closely. This is a clear demonstration of the value of a national cancer audit, as it can act as an early warning signal, prompting closer investigation of individual hospital performance in comparison to others within their region.

4.5 Which patient factors were linked to worse survival?

The study looked at which patient and cancer factors were linked to survival.

Age

As with all cancers, older age was strongly linked to lower survival. Compared with patients aged 18–49, patients aged 80 and over had **more than four times** lower survival compared with the youngest group in the model.

Sex

Men had a slightly lower survival than women (**around 7% lower**).

Deprivation

People living in less deprived areas had better survival than those in the most deprived areas. Compared with the most deprived group (those in the lowest 20% of IMD score), survival was:

- **18% higher** for deprivation group 2 (slightly less deprived areas than the most deprived group)
- **37% higher** for group 3 (moderately deprived areas)
- **47% higher** for group 4 (less deprived areas)
- **59% higher** for the group 5 (the 20% least deprived)

This shows a large increase in survival with decreasing deprivation.

Other health conditions

Patients with other serious illnesses had worse survival. Compared with people with no recorded comorbidity:

- People with one other serious illness had **32% lower survival**.
- People with two comorbidities had **49% lower survival**.
- People with more than two comorbidities had **62% lower survival**.

Tumour site

Compared with larynx cancer:

- **oral cavity cancer** had **22% lower survival**.
- **oropharynx cancer** had **14% higher survival**.

Stage at diagnosis

One of the strongest findings was the effect of stage. Compared with stage 1–2 disease, patients with stage 3–4 disease had **65% lower survival.**

What this means for patients and the public

The survival results show which patient groups have lower survival and where services may need to focus support. People diagnosed at a later stage had much lower survival. Survival was also worse for older people, those with other serious illnesses, those with oral cavity cancer, and those living in more deprived areas.

5. What are the main messages from these results?

Taken together, the results paint a clear picture.

- Head and neck cancer is not evenly spread across England. Some regions carry a greater burden of disease, especially people living in more deprived areas.
- Many patients are diagnosed when their cancer is already advanced. Since stage 3–4 disease is linked to much worse survival, and quality of life outcomes, this points to the need for earlier diagnosis and faster access to specialist assessment.
- Waiting times are a major issue, especially for oncology treatment. Many patients do not start treatment within the 62-day NHS target, and there is wide variation between different parts of the country.
- Survival after diagnosis is influenced by age, stage, deprivation, cancer site, and other health conditions. The strongest messages are that later-stage diagnosis and social inequality are closely linked to worse outcomes.

This study shows that a national audit for head and neck cancer could provide valuable information for improving care. The early findings already show important differences in incidence, stage at diagnosis, waiting times, and survival. They also show inequalities, such as patients from most deprived regions having later diagnosis.

What are the challenges?

While national datasets allow us to measure many important outcomes, some information is missing or incomplete. For example:

- Multidisciplinary team (MDT) meeting data are not reliably recorded.
- Performance status (a measure of how well a patient is) is often missing.
- Information on dental care, rehabilitation services, and patient-reported outcomes (including quality of life outcomes) is limited restricting our understanding of quality of care during treatment and quality of life after treatment.
- Reliable recording of cancer recurrence is not available.

Improving data quality will be important to be able to be able to measure all important indicators in a full national audit.

What happens next?

Over the next year, we will:

- Describe differences in care between NHS hospitals.
- Adjust results for patient and cancer factors to make comparisons between hospitals fair.
- Describe differences in care between patient groups.
- Find out which areas of care have the most room for improvement.
- Look at whether the audit could also include the rarer types of head and neck cancer.

The project is due to finish in March 2027.

Thank you to our funders, collaborators and stakeholders

HEAD & NECK CANCER COALITION

BAHNON
British Association of Head & Neck Oncology Nurses

BAHNO
BRITISH ASSOCIATION OF HEAD & NECK ONCOLOGISTS

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

BAOMS
British Association of Oral and Maxillofacial Surgeons

GIRFT
GETTING IT RIGHT FIRST TIME

RD-UK
Consultant & Specialist Group
Informing, Educating & Inspiring

The International Centre for Recurrent Head & Neck Cancer
Delivered by The Royal Marsden

THE NATIONAL ASSOCIATION OF LARYNGECTOMEE CLUBS

Young Tongues

ORACLE
Head & Neck Cancer UK

north west cancer research

ENTUK

HaNC

Get ahead
Charitable Trust
A cancer charity fighting all head & neck diseases