

## **National Clinical Audit and Patient Outcomes Programme**

### **Project Summary**

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#### **National Head and Neck Cancer Comparative Audit (DAHNO)**

##### **Purpose**

The aim of the national head and neck cancer audit is to achieve comprehensive and consistent data collection producing meaningful results that act as a vehicle to improve delivery of care to patients with head and neck cancer.

##### **Objectives**

The audit objectives are to:

- collect data from all organisations that provide diagnostic and/or treatment services for patients with head and neck cancer
- achieve a level of data quality that enables measurement of professionally defined standards of care
- capture data on all patients in England and Wales with a primary diagnosis of cancer of the larynx, oral cavity, oropharynx, hypopharynx, nasopharynx or major salivary glands
- provide 5 year survival outcomes for larynx and oral cavity patients and 2 year survival outcomes for oropharynx, hypopharynx, nasopharynx and salivary gland patients
- measure current performance and report at trust level on a number of professionally agreed clinical standards
- provide high quality data on a number of defined key measures at cancer network level which can be used for service planning and prioritisation, leading to improvements in the delivery of head and neck cancer care
- provide high quality data on a number of defined key measures at trust level to support workforce planning, recruitment and service development within the specialist nursing and allied health professions
- facilitate the development of professionally agreed standards in collaboration with the British Association of Head and Neck Oncologists (BAHNO)
- provide high quality data to support the measurement of compliance against the BAHNO professional standards and the Improving Outcomes Guidance (IOG)
- for trusts to be able to identify their own practice against the audit's standards and provide a local action plan (LAP) toolkit to facilitate the identification and change of clinical practice which will lead to improved care for head and neck cancer patients
- produce a cumulative database of all reported cases over the life of the audit for use in comparative treatment studies to further improve the quality of care delivered.

### **Methodology:**

A generic methodology in common with other National Clinical Audit Support Programme (NCASP) cancer audits is followed:

- data items are defined in the dataset which are used to answer specific questions regarding the care of patients with head and neck cancer
- the data is entered either manually or through a CSV upload from hospital systems in the system (DAHNO – Data for Head and Neck Oncology)
- data analysis is coordinated by the Oxford Cancer Intelligence Unit.

### **Key quality indicators**

The key quality indicators for head and neck cancer care are defined by the National Institute for Health and Clinical Excellence (NICE) in the Improving Outcomes Guidance and the British Association of Head and Neck Oncologists process standards 2008.

The audit measures performance against a range of these indicators, in the 4<sup>th</sup> Annual Report these included:

- 100% of centres should have a computerised database containing the DAHNO (phase I and II) minimum data-set. 95% of patients' entries must be updated a minimum of annually/until death.
- TNM staging in 100% (*includes TxNxMx*)
- 100% of urgent referrals ('two-week wait') should adhere to national referral guidelines
- General practitioner / dental practitioner referral date to first outpatients visit - 14 days
- Biopsy to report issue 90% by 7 days
- 100% of new cases require a histological diagnosis of cancer prior to treatment planning
- Imaging of chest in 95% of cases prior to treatment planning
- Decision to treat to radiotherapy, chemotherapy (curative intent) 31 days to start radiotherapy 21 days to start of chemotherapy
- Surgical resection to reporting 80% by 14 days (21 if decalcification required)
- Skill standards should include clear surgical margins [no invasive tumour at a margin] for primary tumours in [non-palliative], open surgery with radical intent in 80% of cases
- 30 day and 2 year relative survival to be recorded in 98% of patients
- 100% of patients should be assessed by a suitably qualified dental practitioner before and after their main treatment
- 100% of patients should be seen by a dietician prior to the commencement of treatment
- Specialist head and neck liaison nurse to be present 90%
- Stage at diagnosis
- Five-year survival rates for all patients, with information on cancer grade and stage, co-morbidity, age and other features of case-mix, and primary treatment
- Evidence that every patient is discussed by a suitable MDT at the first opportunity after initial diagnosis and assessment, and when recurrent disease is identified
- Evidence that every patient with UAT cancer has a chest X-ray or CT scan of the chest
- Proportion of patients undergoing laryngectomy who receive surgical voice restoration
- Evidence that surgical voice restoration, and access to appropriate equipment and rehabilitation, is provided for all patients who would be expected to benefit from it
- Audit of adequacy of surgery
- Survival rates in patients with recurrent disease
- Audit of failure rates in the neck, osteonecrosis, and surgical mortality
- Proportion of patients recruited to clinical trials
- Evidence that patients' dental health needs are addressed before radiotherapy

- Evidence that every patient whose treatment is expected to affect eating, swallowing or breathing is assessed by an SLT member of the MDT before treatment begins
- Proportion of patients undergoing laryngectomy who receive surgical voice restoration
- Evidence that every patient's nutritional status and needs are assessed by a dietitian member of the MDT before treatment begins, and that any necessary pre-treatment interventions are provided without delay.

#### **Data collection schedule**

- Data collection – 1st November – 31st October (Date patient diagnosed of Cancer)
- Date extracted – Third week of November
- Date analysed – December – January
- Report written – February
- Report published - End of March

#### **Is the Audit Process or Outcome focused?**

The audit is both process and outcome focused. Survival outcome is measured as well as process standards (NICE and BAHNO see 3 above).

#### **Who is involved in the audit?**

The National Clinical Audit Support Programme (NCASP), within the NHS Information Centre for health and social care, is the main contractor for the audit.

The clinical audit lead on the BAHNO Council, which represents the head and neck cancer professional body, is the project lead for this national audit, thus demonstrating a direct link to the professionals involved in patient care. The president of BAHNO is a member of the audit's project board and all participating trusts have an identified clinical lead on the project.

The project's Clinical Reference Group has membership from the Let's Face It and National Association of Laryngectomy Clubs patient groups. These groups have the opportunity to comment on and contribute to the annual report.

#### **Who are the main stakeholders?**

The audit does not stand in isolation – it is an integral part of national initiatives aimed at service improvement including; BAHNO (the professional body), Cancer Peer Review, NHS Improvement, cancer networks, cancer registries, the National Cancer Intelligence Network (NCIN).

#### **Date of the next Annual Report and outline content**

Three annual reports have been published to date, with the 4<sup>th</sup> due for publication in 31 March 2010.

Over time these reports have evolved with an increasing focus on reporting trust identifiable results. A summary report is produced aimed at the public and non-clinical staff. With the 4<sup>th</sup> Annual Report a reference report will be made available giving further details of the findings from the main report.

**More information:** <http://www.ic.nhs.uk/services/national-clinical-audit-support-programme-ncasp/cancer/head-and-neck>