National Head and Neck Cancer Audit

Summary report and recommendations from the National Head and Neck Cancer Audit for England and Wales

Report for the audit period November 2006 to October 2007
“This audit will give much needed information for dedicated patient user groups to discuss improvements to important features of the patient ‘cancer journey’ including waiting times, and service provision. Patients can expect additional benefits with the development of this information resource, in future annual reports.”

Gerry Humphris  
Chair in Health Psychology,  
University of St Andrews and Honorary Clinical Psychologist, Edinburgh Cancer Centre

“Head and neck cancer and its treatment may result in disabling and life-changing swallowing and communication difficulties. Speech and language therapists offer supportive care and rehabilitation to both patients and their families. It is crucial that we collect multi-centre information systematically, to ensure that there is equity of access to our services, to deliver care where it is needed and to better inform us on the functional outcomes of life after cancer.”

Jo Patterson  
Macmillan Speech and Language Therapist,  
Sunderland Royal Hospital and University of Newcastle

“Head and neck cancer and its treatment can significantly impair a patient’s ability to eat, drink and maintain an adequate nutritional intake. Nutrition impacts profoundly on patient’s clinical outcomes and quality of life. Dietitians are an integral part of the team, providing nutritional assessment, support and advice for patients and carers. It is vital that we work with our multi-disciplinary teams to undertake national audit to better inform us, improve patient’s nutritional care and access to dietetic services.”

Sarah Cameron  
Macmillan Specialist Head and Neck Oncology Dietitian,  
St James’s Institute of Oncology, Leeds
National Head and Neck Cancer Audit

Summary report and recommendations from the National Head and Neck Cancer Audit for England and Wales

Report for the audit period November 2006 to October 2007
National Head and Neck Cancer Audit

Summary report and recommendations from the National Head and Neck Cancer Audit for England and Wales

Report for the audit period November 2006 to October 2007

This summary report and recommendations is based on the third report for the National Head and Neck Cancer Audit presents data collected on new registrations from 1 November 2006 to 31 October 2007 and treatment data up to the 19 November 2007.

The report reflects the analysis of that data, and provides recommendations for improving data quality and completeness. DAHNO, by means of a continuous electronic audit on the management of head and neck cancer in England and Wales, aims to provide comparative feedback to NHS Provider Trusts, with the ultimate aim of improving patient care.

The full report can be ordered from The NHS Information Centre for health and social care's (The NHS IC) Contact Centre 0845 300 6016 or email: enquiries@ic.nhs.uk quoting document reference 28010408. For further information about this report, email: enquiries@ic.nhs.uk.

Electronic copies of this report can be found at:

www.ic.nhs.uk/canceraudits

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Acknowledgements

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The audit team wishes to acknowledge the following individuals and groups who have supported the audit and provided guidance during the data collection period, 1 November 2006 to 31 October 2007, and during the compilation of this report:

Dick Waite and Helen Laing of the Healthcare Commission, for their continued sponsorship and support for the audit.

The audit project team: Chair Richard Wight, Vice Chair, Graham Putnam, Project Manager Julie Michalowski, Former Project Manager Paul Theato, Senior Project Manager (Cancer Audits) Steve Dean, DAHNO Application Developer Ronnie Brar, Data Manager Nancy Horseman, Project Support Officer Clare Bailey and Former Project Support Officer Mary Boden.

Charlotte Tye, of the NHS IC Marketing and Communications Team, for her assistance throughout the year in publicising the audit and with the publication of this report. Isis Hreczuk-Hirst of the IC Datasets team for her support of data-related issues.

Jeff Stamatakis, Simon Hodder and Jackie Davies at Informing Healthcare for their contribution from Wales to the audit.

The following groups have supported the audit; the Data Management and Analysis Group, the User Group and the Head and Neck Clinical Reference Group.

We would also like to acknowledge David Cunningham, for the initial development of the DAHNO application, and Ronnie Brar for continued development and system maintenance.

The analysis for this report was undertaken by the cancer registries and special thanks must be given to; Sandra Edwards from the Oxford Cancer Intelligence Unit, Ceri White from the Welsh Cancer Intelligence and Surveillance Unit, Sarah Cuthbertson and Jason Poole from Trent Cancer Registry, with the support of Ruth Jack and Henrik Møller at the Thames Cancer Registry.

Finally, thanks go to all those organisations that have participated in the audit so far, and for the individual contributions of clinicians, managers and administrative staff without whose efforts the audit would not be able to deliver. Thank you also to all those patients whose data is contributing towards bringing about improvements in the provision of care and outcomes for all those similarly afflicted by head and neck cancer.

NHS Connecting for Health, and previously the NHS Information Authority, supported the technical infrastructure. We would particularly like to acknowledge Gary Sargent and Sandy Garrity who provided helpdesk support to users.
Foreword

I welcome this third annual report of the National Head and Neck Cancer Audit. I am delighted that case ascertainment across England and Wales has risen and that completeness of data on staging has improved. However, with only two thirds of incident cases being reported there is clearly a need for further improvement. In particular, those organisations which have yet to contribute data should now make this a priority.

The Cancer Reform Strategy for England, published in December 2007, emphasises the importance of complete and accurate information as a driver for quality improvement. Comparative information can help clinical teams to identify areas where action needs to be taken to improve performance and outcomes. Information is also needed for strong commissioning and by patients who wish to make informed choices.

This audit provides useful information on the average intervals between diagnosis and treatment for patients with laryngeal and oral cancer. This should provide a useful baseline for Trusts in England as they prepare to achieve the waiting time targets set out in the Cancer Reform Strategy.

Considerable progress has been made in overall case ascertainment. The central role of the MDT meeting with multi professional discussion and agreement of a care plan for each newly diagnosed patient supported by collection of clinical data, as emphasised in this report, must remain priorities.

Whilst case ascertainment has dropped a little this year, case ascertainment for the Welsh Cancer Networks remains very good and may be due to the fact that our national cancer information system, CANISC, is also used to collect and report on the 31/62 day waiting times targets. Our next priority is to improve on recording the stage of disease. During 2008 roll out will commence of on-screen histopathology reporting that will feed directly into CANISC. We expect this will make a significant improvement that will be reflected in future National Head and Neck Cancer Annual Reports.

Professor Mike Richards CBE
National Cancer Director

Dr Jane Hanson
Advisor for Cancer Services to the Wales Assembly Government and Director of the Cancer Services Co-ordinating Group
The third annual report, examines data submitted from November 2006 until October 2007. Milestones have been achieved with over 2,000 cases of larynx and oral cavity cancer submitted this year and over 4,500 since the inception of the audit in 2004. 34 out of 36 networks are now actively submitting data across England and Wales.

The aim of the audit remains to achieve comprehensive and consistent data collection producing meaningful results, that provide a vehicle to improve delivery of care to patients with head and neck cancer. The benefits section sets out some of the achievements so far and will expand as the audit progresses.

The success of the audit is dependent on contributions made by individual clinicians and their support staff across the country. This annual report represents their continuing labours, facilitated and supported by NHS Provider Trusts and Cancer Networks.

This audit benefits from the knowledge and commitment of the National Clinical Audit Support Programme (NCASP) team, and the continued support of the Healthcare Commission.

For patients, the third report has extensive sections showing, for the first time, trust identifiable information and this will be expanded in future years.

Further pieces of the complex puzzle of head and neck cancer care have been revealed, and as comprehensive submissions continue to rise, a more complete picture of head and neck cancer will emerge. This report is another stride along this road.

Richard Wight FRCS
Consultant Head and Neck Surgeon
National Head and Neck Cancer Audit Project Chair

Graham Putnam FRCS
Consultant Head and Neck Surgeon
National Head and Neck Cancer Audit Project Vice Chair
1 Executive Summary

1.0 Executive Summary of the Full Report

The third National Head and Neck Cancer Audit annual report on the management of head and neck cancer in England and Wales includes a brief background to this type of cancer and a description of the infrastructure, methods and analysis used within the audit. Improvements and benefits from the audit and detailed recommendations are included in the report, along with detailed findings which incorporate outcomes in both carcinoma of the larynx and oral cavity.

The third annual report includes a wide variety of outcomes provided in a trust identifiable format for the first time.

Throughout the full report, significant points for consideration are shown, whilst practical examples of methods that improve data collection and collation can be found in the Good Practice Example boxes and at: www.ic.nhs.uk/cancer audits.

Submission by Provider Trust/Cancer Network is published, as well as listing those organisations who submit on behalf of other trusts.

1.1 What is DAHNO?

DAHNO (Data for Head and Neck Oncology), provides a continuous electronic comparative audit on management of head and neck cancer. It is supported by professional bodies and funded by the Healthcare Commission.

The disease burden of head and neck cancer is significant. Patients require intensive investigation, multi-modality treatments and rehabilitation with long-term support to achieve an adequate recovery.

Core issues addressed in the first phase of the National Head and Neck Cancer Audit are:

- delivery of appropriate primary treatment (including adjuvant therapy) in the management of head and neck cancer affecting the larynx and oral cavity by a multi professional team.
- delivery of care to agreed standards.

1.2 What the National Head and Neck Cancer Audit adds to existing information

To confirm the quality of care delivered, anonymised data on individual patients needs to be collected and analysed. The Head and Neck Cancer Audit continuously collects data at each patient service contact, and this record is continually updated. Clinical aspects of staging and other casemix factors can be more easily collected.

In the third annual report the following findings are reported in Trust identifiable format:

- participation
- number of new larynx and oral cavity cancer primaries
- percentage of those cases submitted with T and N category recorded
- interval from biopsy to reporting
- percentage of cases discussed at MDT
- interval from diagnosis to MDT
- interval from diagnosis to first definitive treatment (radiotherapy and surgery).

1.3 Where head and neck cancer care happens - submission rates

1.3.1 Contributing Cancer Networks in England and Wales

The third annual report covers the period 1 November 2006 to 31 October 2007. Each of the thirty six Cancer Networks in England and Wales have had an opportunity to contribute. Two Networks failed to submit any cases - North London Cancer Network and South East London Cancer Network.

Thirty one English Cancer Networks and all three Welsh Cancer Networks have submitted patient records, and the third annual report describes results for over 2,000 patient records – a 50 per cent increase. Thirteen Cancer Networks have managed to achieve high levels of registration with in excess of 90 per cent of the expected case numbers recorded.
1.3.2 Overview of case ascertainment

The data collection period (12 months) showed a rise in case ascertainment to 67 per cent (2,035 of an estimated 3,032 cases in England and Wales). In England, 1,882 cases of an estimated 2,820 cases were submitted (67 per cent) which is a significant rise with improved data completeness particularly on staging.

In Wales, 153 cases of an estimated 212 cases were submitted (72 per cent), which is a high level but with varying data completeness.

Whilst the improved case ascertainment is welcomed, executive teams in organisations yet to contribute should ensure prioritisation of the National Head and Neck Cancer Audit in their audit programmes. Participation in this audit is part of the Healthcare Commission’s Annual Health check, and the peer review process continuing in 2008.

Complete and comprehensive submission provides a vehicle for assurance to trust boards and patient groups of the quality of care delivered in head and neck cancer. Additionally with complete data submission it will become possible to identify areas where action is required to ensure that care is improved to the highest standards.

1.4 Key overall findings

1.4.1 The pivotal role of the multi disciplinary (MDT) meeting

Patient expectations and Improving Outcomes Guidance (IOG) are that all care discussions are made at a MDT, and head and neck cancer teams need to provide assurance to Trust boards on this aspect of care delivery.

93 per cent of submitted cases were confirmed as having been discussed at a multidisciplinary meeting. (this represents 74 per cent of patients submitted)

A small but significant number (5.8 per cent) were recorded as not having been discussed.

A number of providers have higher than average rates of non discussion and the project team will be alerting those organisations where high levels of not discussed are recorded to consider the reasons for this and to develop improvement plans.

20 per cent did not have this important item recorded, from which is not possible to be certain on the overall national discussion rate which could lie in the range 74 to 93 per cent. This still leaves doubt that treatment decisions for patients could be being made outside of MDTs.

1.4.2 Speech and language and dietetic provision

Pre-treatment speech and swallowing and dietetic assessment recording has improved but still only for a small percentage of registrations and is likely to reflect poor data quality. Whilst the expert panel members believe that this is not a true reflection of current practice, they are aware of nationwide shortages in allied health professional roles to support cancer MDTs. Patient representatives feel it is imperative that speech and swallowing and dietetic support is available to all patients with head and neck cancer from the point of diagnosis to enhance patient care.

1.5 Who receives the care?

1,045 cases of larynx cancer and 986 cases of oral cavity cancer were submitted.

Cancer of the larynx and oral cavity is again shown as a disease of older age groups in the pooled data of 46 months of data collection (90 per cent greater than 50 years old) with males predominating.

1.5.1 The patient journey

Consideration of submitted data and informal feedback from expert panels, demonstrates general dental practitioners do not appear to be embracing the two week rule referrals pathway in some Networks and in others are not actively involved in the referral process. One in five oral cavity cancer patients are referred via the general dental practitioner/community dental service route, but of these only a quarter are via the two week wait urgent referral pathway. The Networks need to examine local pathways and their effective usage.

Understanding is growing of factors responsible for recognition of signs and symptoms in patients that encourage a visit to a doctor or dentist. Furthermore, the variation of the interval from first recognition of suspicious symptoms to diagnosis, as shown by this audit, beg questions of the psychological response to possible malignancy, not only by patients but also care-givers.
There are several methods of obtaining a biopsy in order to reach a diagnosis, and the most appropriate method will be determined by the clinical presentation. The median time from biopsy to its reporting is 3 days for larynx and 4 days for oral cavity, which is an improvement. However it is noted that 24 per cent of oral cavity cases reported have an interval greater than 10 days. This is shown by provider trust and confirms this represents both a delay in a small number of organisations and a variation within providers. To improve the patient pathway process mapping may identify areas where delays in the whole pathway could be reduced (from taking of a biopsy, through to its reporting). Manpower issues within pathology and in particularly head and neck pathology remain a challenge.

A smaller number of patients show delays in diagnostic imaging, which is an improvement from the first report. Local teams should assess the timeliness of imaging and seek to reduce delay if applicable.

The investigation of cancer wait times was expected to reduce patient journey times, whilst median time has reduced in the study period, considerable work remains to achieve these targets for all patients. Booked care and clearly defined patient pathways are key factors to minimise delay. The site specific group should see performance reporting as a routine agenda item, supported by monitored action plans if avoidable delay is evident.

1.5.2 Care provided

In the treatment of laryngeal cancer patients, radiotherapy remains the most common first treatment. However a previously noted trend in treatment via endolaryngeal resection, has not continued this year. The current evidence base does not support the superiority of one treatment over another. DAHNO provides a unique opportunity to track this and other treatment changes in a high quality clinical database containing sufficient information to allow casemix adjusted outcomes.

For surgery, the median interval from diagnosis to first recorded treatment is 25 days but for those undergoing primary radiotherapy a median time of 45 days was found, showing no reduction in comparison to the second annual report. An analysis by provider trust shows wide variation in intervals within organisations as well as between organisations for radiotherapy.

The majority of oral cavity patients have surgery as a first treatment with a median time to operation of 33 days from diagnosis. For the smaller number who undergo primary radiotherapy, the median interval to commencement of treatment is 52 days. An analysis by provider trust shows wide variation in intervals within organisations as well as between organisations for surgery.

The interval to commencing radiotherapy has remained static, as highlighted in last years report, this still suggests that head and neck cancer patients continue to have difficulty in accessing radiotherapy services. Provider organisations for radiotherapy should review patient pathways, as well as the resource committed to head and neck cancer, with the aim of avoiding unnecessary delays.

The expert panels noted the importance of collection of actual care delivered along the whole patient pathway and that this is currently inadequate, to allow proper assurance in the complex multi professional management of head and neck cancer.

1.6 Recommendations

The third analysis has again demonstrated variability in record completeness between different organisations and between individual records. High levels of submission and completeness of records are required to gain the most value from the audit. NHS Provider Trusts and Cancer Networks should facilitate data collection through the MDT by providing resources, training and direction.

Trusts, MDTs and site specific groups should review the recommendations below and develop action plans using the soon to be released action planning tool for any deficiencies.

Trusts, MDTs and Networks should as a priority:

- develop a local action plan based on the findings in the audit using the action planning tool that has been developed by the National Head and Neck cancer audit team
- ensure that Cancer Networks reflect on where variation in access occurs within the Network as identified in trust identifiable data and seek to examine pathways that underpin it
Executive Summary

- ensure that tumour staging (TNM) is confirmed and recorded prior to care planning and following surgical procedures

- facilitate meeting patient expectations that all care discussions are being made at a MDT, and head and neck cancer teams need to provide assurance around this important aspect of care delivery. This is unanimously supported by the Expert Panels

- ensure that all Cancer Networks and constituent Provider Trusts not achieving high levels or any level of case submission review their processes and support for submission of data. Best practice supporting data collection can be found at: www.ic.nhs.uk/canceraudits

- ensure that all MDTs should seek to accurately capture resective pathology information including pathological stage for every patient undergoing surgical treatment. This will enable true stage comparison of outcomes

- ensure that Provider trusts uploading information via CSV should commence preparation of CSV requirements to meet Phase II as well as attending future workshops.

Full details of all recommendations from the report can be found in Section 2.0 of this summary report and 6.2 of the full report. This should be used by organisations when formulating local action plans.

1.7 Key aspects for the current collection year November 2007 – October 2008

The future versions of this annual report will increase reporting of outcomes by contributory provider trust and team, thus the importance of routine collection of factors that contribute to risk adjustment to allow true comparisons to be made. (stage, co-morbidity and performance status)

The index year cohort currently reported will be used to apply casemix adjustment and to develop a casemix adjustment model for the fourth report.

Phase II has commenced and extends the audit to cover a wider range of anatomic sites (nasopharynx, oropharynx, hypopharynx and major salivary glands) a wider range of pathologies and a more in depth assessment of multi-professional involvement (surgical voice restoration, dietetic and clinical nurse specialist)

For Phase II a new system infrastructure is available – web DAHNO, and more information can be found at www.ic.nhs.uk/canceraudits

1.8 Good Practice

This year it has been possible to capture good practice happening across England and Wales which result in achieving excellent standards of care, case ascertainment and data quality. From this it has been possible to identify key factors which, if present, increase benefits gained by an organisation from participation in the audit.

Key factors influencing improvements in case ascertainment and data quality:

- a committed clinical team who understand the benefits and requirements of the audit
- close working between clinical and administrative staff in a supporting environment
- dedicated administrative staff to capture data and provide data quality checks
- close working relationships with the information and IT departments to maximise the use of technology in data capture and validation
- systems and processes to check (ideally by clinicians) data to be entered into DAHNO.

Whilst there is still room for improvement in terms of data completeness, levels of case ascertainment and data quality have improved significantly for a number of performance measures to be shown at trust level and have been incorporated into this report.

The third annual report has included a number of examples of good practice case studies of how organisations have achieved good results which may be useful for others.
### 1.9 Participating Trusts

The data quality calculation can be found in Appendix 9 of the full report.

The score if all expected cases are submitted with all index events is 100. An allowance is made for diagnostic only centres in comparison to diagnostic and treatment centres. A poor level of data completeness is recorded if a score of less than 26 is achieved, and reflects, for example 50 per cent of estimated cases with 50 per cent completeness. A submission of under five cases automatically records poor data completeness.

#### Figure 1.9 Participating Trusts

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**Central South Coast Cancer Network**
- Basingstoke and North Hampshire NHS Foundation Trust
- Isle Of Wight Healthcare NHS Trust
- Portsmouth Hospitals NHS Trust
- Royal West Sussex NHS Trust
- Salisbury NHS Foundation Trust
- Southampton University Hospitals NHS Trust
- Winchester and Eastleigh Healthcare NHS Trust

**Derby Burton Cancer Network**
- Burton Hospitals NHS Trust
- Derby Hospitals NHS Foundation Trust

**Dorset Cancer Network**
- Dorset County Hospitals NHS Foundation Trust
- Poole Hospital NHS Foundation Trust
- Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

**Essex Cancer Network**
- Basildon and Thurrock University Hospitals NHS Foundation Trust
- Essex Rivers Healthcare NHS Trust
- Mid Essex Hospital Services NHS Trust
- Southend Hospital NHS Trust

**Greater Manchester and Cheshire Cancer Network**
- Bolton Hospitals NHS Trust
- Central Manchester and Manchester Children’s University Hospitals NHS Trust
- Christie Hospital NHS Foundation Trust
- East Cheshire NHS Trust
- Pennine Acute Hospitals NHS Trust
- Salford Royal NHS Foundation Trust
- Stockport NHS Foundation Trust
- Tameside and Glossop Acute Services NHS Trust
- The Mid Cheshire Hospitals NHS Trust
- Trafford Healthcare NHS Trust
- University Hospitals of South Manchester NHS Foundation Trust
- Warrington, Wigan and Leigh NHS Trust

**Greater Midlands Cancer Network**
- Dudley Group of Hospitals NHS Trust
- Mid Staffordshire General Hospitals NHS Trust
- Shrewsbury and Telford Hospital NHS Trust
- The Royal Wolverhampton Hospitals NHS Trust
- University Hospital of North Staffordshire NHS Trust
- Worcestershire Acute Hospitals NHS Trust
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### North London Cancer Network
- Barnet and Chase Farm Hospitals NHS Trust
- North Middlesex University Hospital NHS Trust
- Royal Free Hampstead NHS Trust
- The Princess Alexandra Hospital NHS Trust
- The Whittington Hospital NHS Trust
- University College London Hospitals NHS Foundation Trust

### North of England Cancer Network
- City Hospitals Sunderland NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust
- Gateshead Health NHS Foundation Trust
- North Cumbria Acute Hospitals NHS Trust
- Northumbria Healthcare NHS Foundation Trust
- South Tees Hospitals NHS Trust
- South Tyneside NHS Foundation Trust
- The Newcastle upon Tyne Hospitals NHS Foundation Trust

### North Trent Cancer Network
- Barnsley Hospital NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- The Rotherham NHS Foundation Trust

### Pan Birmingham Cancer Network
- Heart Of England NHS Foundation Trust
- Sandwell and West Birmingham Hospitals NHS Trust
- University Hospital Birmingham NHS Foundation Trust
- Worcestershire Acute Hospitals NHS Trust

### Peninsula Cancer Network
- Northern Devon Healthcare NHS Trust
- Plymouth Hospitals NHS Trust
- Royal Cornwall Hospitals NHS Trust
- Royal Devon and Exeter NHS Foundation Trust
- South Devon Healthcare NHS Foundation Trust

### South East London Cancer Network
- Bromley Hospitals NHS Trust
- Guy's and St Thomas’ NHS Foundation Trust
- King’s College Hospital NHS Foundation Trust
- Queen Mary’s Sidcup NHS Trust
- The Lewisham Hospital NHS Trust
### Executive Summary

#### South West London Cancer Network
- Epsom and St Helier University Hospitals NHS Trust
- Kingston Hospital NHS Trust
- Mayday Healthcare NHS Trust
- St George’s Healthcare NHS Trust
- The Royal Marsden NHS Foundation Trust

#### Surrey, West Sussex and Hampshire Cancer Network
- Ashford and St Peter’s Hospitals NHS Trust
- Frimley Park Hospital NHS Foundation Trust
- Royal Surrey County Hospital NHS Trust
- Surrey and Sussex Healthcare NHS Trust

#### Sussex Cancer Network
- Brighton and Sussex University Hospitals NHS Trust
- East Sussex Hospitals NHS Trust
- Worthing and Southlands Hospitals NHS Trust

#### Thames Valley Cancer Network
- Buckinghamshire Hospitals NHS Trust
- Heatherwood and Wexham Park Hospitals NHS Foundation Trust
- Milton Keynes Hospital NHS Foundation Trust
- Oxford Radcliffe Hospitals NHS Trust
- Royal Berkshire NHS Foundation Trust
- Swindon and Marlborough NHS Trust

#### West London Cancer Network
- Ealing Hospital NHS Trust
- Imperial College Healthcare NHS Trust
- North West London Hospitals NHS Trust
- The Hillingdon Hospital NHS Trust
- West Middlesex University Hospital NHS Trust

#### Yorkshire Cancer Network
- Airedale NHS Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- Mid Yorkshire Hospitals NHS Trust
- York Hospitals NHS Foundation Trust

#### North Wales Cancer Network
- Conwy and Denbighshire NHS Trust
- North East Wales NHS Trust
- North West Wales NHS Trust
### South East Wales Cancer Network
- Cardiff and Vale NHS Trust
- Gwent Healthcare NHS Trust
- North Glamorgan NHS Trust
- Velindre NHS Trust

### South West Wales Cancer Network
- Bromorgannwg NHS Trust
- Carmarthenshire NHS Trust
- Ceredigion and Mid Wales NHS Trust
- Pembrokeshire and Derwen NHS Trust
- Swansea NHS Trust
### Figure 2.0 Issues and recommendations

**KEY RECOMMENDATIONS** – high priority in red text

N = NETWORK  T = PROVIDER TRUST  U = USERS  P = PROFESSIONS  D = DAHNO PROJECT  M = Multidisciplinary teams

<table>
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<tr>
<th>Issues</th>
<th>Recommendations (high priority in blue text)</th>
<th>Group to action</th>
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| 2.1 Developing a local response to the audit findings | • each trust should develop an action plan based on the findings in the audit  
• an action planning tool will be released to coincide with production of local reports in summer 2008  
• networks should facilitate comprehensive introduction of the action planning tool  
• a local analysis tool has been commissioned by NCASP and will be available in autumn 2008 to support local analysis of a selection of outputs. | N T U M |
| 2.2 Developing a network response to the audit findings | • each network should liaise with provider trusts to support a comprehensive audit process in head and neck cancer  
• the network should encourage head and neck tumour site specific groups to regularly discuss comparative audit on their agendas and provider trusts to provide an appropriate infrastructure  
• networks should reflect on where variation in access occurs within the network as identified in trust identifiable data and seek to examine pathways that underpin it. | N T M |
### 2.3 Clinical issues for multidisciplinary teams

A number of issues have been highlighted in the report. The Expert Panel had concerns about the care delivered, based on the data submitted. This may reflect the absence of collection rather than true practice. However, the teams should assess their local delivery against the items opposite.

**MDTs should:**
- Ensure the timeliness of pathways to meet national access targets
- Ensure the awareness and involvement of general dental practitioners and community dental services in urgent cancer referral processes
- Ensure that speech and language therapists and dieticians have active involvement in patient management and their care pathways (see below re Phase II)
- Ensure that tumour staging (TNM) is confirmed and recorded prior to care planning and following surgical procedures
- Ensure that good dental health is maintained throughout treatment
- Ensure provision of surgical voice restoration counselling, pre-treatment, for all patients having a laryngectomy
- Ensure provision of swallowing counselling, pre-treatment, for all patients who are about to undergo oral and oropharyngeal resective and or reconstructive surgery with free tissue transfer or partial laryngo-pharyngeal surgery
- Should ensure that delays in commencement of radiotherapy/chemotherapy – either as primary or adjunctive treatment - are minimised
- Ensure the recording of all treatments by identifying and documenting any reasons for the provision of chemotherapy in isolation as first line treatment, and where it is used as part of a chemo-radiation regime
- Facilitate meeting patient expectations that all care discussions are being made at a MDT, and head and neck cancer teams need to provide assurance around this important aspect of care delivery. This is unanimously supported by the expert panels
- Each MDT should review on a case by case basis as to why decisions are made outside of the MDT, and put steps in place to ensure all cases are discussed
- Teams should confirm that chest imaging has occurred in all head and neck cancer patients prior to planning treatment as synchronous malignancies of the chest can occur and have a significant impact on treatment options
- For accurate understanding of care pathways it is important that all components of a surgical procedure are recorded to provide a true reflection of the breadth and complexity of surgical management
- A general theme of the analysis is that the second phase of treatment is not being well captured. This may reflect MDT data capture processes. Teams are encouraged to capture all parts of the patients’ careplan.

### 2.4 Standards in clinical care

Professional bodies, led by the British Association of Head and Neck Oncologists (BAHNO) and facilitated by the National Head and Neck Cancer Audit team, are evolving clinical standards.

Support and comply with evolving clinical standards as they become available in 2008.
### 2.5 Data quality and completeness

**The public should have access to accurate and risk adjusted clinical information.**

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| 67 per cent of potential records submitted. Two Cancer Networks have no submissions to this second annual report. | • Each provider trust should seek to provide assurance on the quality and timeliness of care delivered to head and neck cancer patients by comprehensive and continuous contribution to the audit.  
• The head and neck cancer audit team will continue to expand the volume of trust identifiable data reported as data becomes more robust.  
To provide risk adjustment requires high levels and data quality and completeness. During audit rollout assumptions have been made that poor or missing data did not necessarily represent actual treatment given. Now that the audit is established this assumption is inappropriate and poor or missing data will be reflected as the treatment given:  
• Networks should increase local awareness and encourage compliance with the audit.  
• Provider Trusts should support local provision of data collection not only at commencement of treatment, but through follow up to include data on current treatment and rehabilitation.  
• Users and professionals should contribute to both support data collection and maintain consistency and quality of data collected.  
Users should familiarise themselves with all the items detailed within the audit, and use opportunities to attend DAHNO workshops. The influence of factors such as co-morbidity and performance status can have a significant effect upon treatment outcomes. Therefore all MDTs should collect these data set items. | T M D |
| Absence of resective pathology information in submissions. | All Cancer Networks and constituent Provider Trusts not achieving high levels or any level of case submission should review their processes and support for submission of data. Best practice supporting data collection can be found at: www.ic.nhs.uk/canceraudits | N T U P |
| Absence of submission completeness on key fields eg certainty factor, performance status and co-morbidity. | All MDTs should seek to accurately capture resective pathology information including pathological stage for every patient undergoing surgical treatment. This will enable true stage comparison of outcomes. | N T U P |

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### 2.6 Data process issues

**Continued identification of teams delivering cancer care.**

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| Absence of data submission on dietician, speech and language, radiotherapy, palliative care activity. | All networks will be regularly contacted by the Head and Neck cancer audit team to confirm contacts at Provider Trusts/hospitals that deliver head and neck cancer care.  
Organisations should review the data collection process and ensure that it extends across the whole pathway. | D N |
|  | | N T U |
## Improvements and Recommendations

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| **2.7 Application issues-web DAHNO and Phase II**  
Launch of web DAHNO.  
Uploading from third party systems.  
Reporting of import errors. | A web based access to DAHNO has been introduced (January 2008) in response to user requests for a more user friendly environment. Details on this and registration requirements can be found at www.ic.nhs.uk/canceraudits.  
The web version contains all the required fields for Phase II.  
The head and neck cancer audit team continue to advise IT providers of requirements to achieve successful upload.  
Provider trusts uploading information should perform this on a regular basis throughout the index year.  
Provider trusts uploading information via csv should commence preparation of csv requirements to meet Phase II as well as attending future workshops.  
The head and neck cancer audit team to proactively advise users via central import log of issues with import. | D  
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| **2.8 Audit data to support clinical process**  
Contemporaneous data collection | Although DAHNO is an audit process the timely collection of patient pathway data can support and expedite the overall delivery of patient care. | N  
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U |
Electronic copies of the National Head and Neck Cancer Audit report can be downloaded from the improving patient care section of our website.

Printed copies of this report can be ordered through our Contact Centre, quoting document reference 28010508.

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