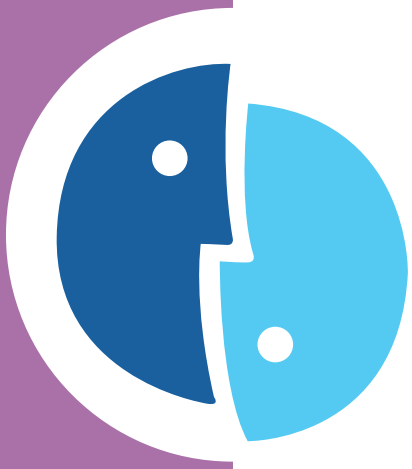
Saving Faces



DAHNO database

Map quality measures to guidelines

Version 2.0
8 September 2016

Relationship between the audit quality measures to be reported and the national guidelines and standards to which they relate

N.B. Audit Questions relate to the DAHNO head and neck cancer data specification and audit data collected in DAHNO format from 1st November 2014 to 31st October 2016.

Audit Question	Guideline or Standard
What proportion of cancer patients are being referred urgently?	Patients who meet the Department of Health's criteria for urgent (two week) referral should either be referred directly to the designated lead head and neck clinician at a local DGH which provides such services, or to a rapid-access neck lump assessment clinic. NICE Improving Outcomes Guideline 2004 (page 29)
Is there a delay between referral and seeing a cancer specialist?	Since 2001, the Department of Health has required that patients referred urgently for possible cancer be seen by a specialist within two weeks. NICE Improving Outcomes Guideline 2004 (page 34)
Was the patient reviewed by a dietician pre-treatment?	Dietetic support is important through all parts of the patient pathway, particularly in those undergoing any form of treatment where the morbidity of the treatment can be reduced by appropriate intervention. MDTs are encouraged to confirm the dietetic care provided.**100 per cent of patients should be seen by a dietician prior to the commencement of treatment.** BAHNO Standard 2009 (page 9)
Was patient reviewed by a dietician post-treatment?	75% of patients should be in a clinic setting for follow up where same-day, same-hospital access to dietetic, specialist head and neck nurse and specialist speech and swallowing advice is available. BAHNO Standard 2009 (page 14)
Was the pre-treatment TNM stage recorded?	Recording cancer site and accurate stage is a key medical responsibility, with best practice suggesting that this should be clearly documented and captured at the MDT. Staging remains a key influence on outcome. It is important that this improves to achieve 100% of cases staged, to allow valid comparisons to be made. Head and Neck CLE 2012-2013 (page 2)
Did the patient see clinical nurse specialist before treatment?	100% of patients should be seen by a specialist head and neck liaison nurse (e.g. Macmillan), whose contact details should be provided to all patients at the earliest opportunity. BAHNO Standard 2009 (page 17)
Was CT chest performed prior to treatment?	Imaging of chest in 95 per cent of cases prior to treatment planning. BAHNO Standard 2009 (page 11)
What proportion of patients with oropharyngeal tumours are having HPV testing of their tumours?	Determination of HPV positivity should be introduced into the routine assessment of patients with oropharyngeal cancer. Head and Neck ENT Guideline 2011 (page 12) HPV testing for oropharyngeal cancer should be performed within a diagnostic service where the laboratory procedures and reporting standards are quality assured. Head and Neck ENT Guideline 2011 (page 139)

Audit Question	Guideline or Standard
Was resective pathology discussed at MDT?	Histopathologists should report on surgical specimens using dataset proformas developed by the Royal College of Pathologists, and if possible, photograph specimens for discussion by the MDT. Pathology departments which deal with head and neck cancers should participate in external quality assurance (EQA) schemes. NICE Improving Outcomes Guideline 2004 (page 78)
What proportion of patients had the cancer care plan intent recorded before treatment?	Both a surgeon and an oncologist should be involved in the consultation and planning in 100% of cases The aim of treatment (cure/palliation) should be documented at the first combined clinic in 80% of cases. The treatment plan should be communicated to the patient and carers verbally, and to the GP in writing, within 3 days in 75% of cases. BAHNO Standard 2009 (page 8, 17)
What proportion of patients had their pre-treatment TNM stage recorded?	TNM staging in 100% (includes TxNxMx). BAHNO Standard 2009 (page 11)

Other Audit Questions

Audit Question	Rationale
Was BMI collected pre-treatment?	Patients with head and neck cancer may be malnourished before treatment because of pain or difficulty eating. This is a risk factor for treatment outcome. The treatment itself may also result in difficulty eating or swallowing. BMI Is therefore an important pretreatment measure and sequential measure following treatment to audit the results of different treatments and to identify patients who may need intensive nutritional support and alternative methods of nutritional supplementation.
What proportion of patients had their diet assessed by a dietitian 3 months after treatment?	The nutritional needs of patients diagnosed with head and neck cancer are often very complex as many present with nutritional problems at diagnosis which are further exacerbated by the debilitating side effects of multi-modality treatment. Diet assessments at 3 months and 12 months can inform individualised nutrition counselling by a registered dietitian which may improve nutritional intake, status and quality of life.
What proportion of patients had their diet assessed by a dietitian 12 months after treatment?	The nutritional needs of patients diagnosed with head and neck cancer are often very complex as many present with nutritional problems at diagnosis which are further exacerbated by the debilitating side effects of multi-modality treatment. Diet assessments at 3 months and 12 months can inform individualised nutrition counselling by a registered dietitian which may improve nutritional intake, status and quality of life.
Did the patient have a pre-treatment speech and language therapy assessment?	Patients whose speech or swallowing could be adversely affected by treatment need to see a speech and language therapist before treatment. These patients will need assessment, future treatment planning and advice from the speech and language therapists at this stage.
Was Laryngectomy communication method at 12 months recorded in those patients who had been treated with Laryngectomy?	Communicating after laryngectomy can be very challenging. Speech improves considerably between six months and one year after total laryngectomy. One year post treatment is therefore an important point in the follow-up care pathway.
Was MRI primary and neck performed prior to treatment?	Appropriate imaging helps to improve the accuracy in defining the extent of disease and thus informs the MDT in the treatment planning process. Currently, MRI is the most sensitive imaging test of the head in routine clinical practice.
Was Ultrasound neck performed prior to treatment?	Appropriate imaging helps to improve the accuracy in defining the extent of disease and thus informs the MDT in the treatment planning process. Ultrasound provides an assessment of the size and appearance of the lymph nodes in the neck. A combination of neck ultrasonography and fine needle aspiration improves the specificity of staging of neck lymph nodes.

Audit Question	Rationale
Did the patient have their weight measured at any post treatment appointment?	Weight loss is frequently noted among head and neck cancer patients during and after treatment and has been found to be related to increased mortality. A post treatment assessment of weight can provide an indication of poor nutritional status.
What proportion of patients had their performance status recorded?	Risk adjustment allows a meaningful comparison of similar cases and allows variation in treatments and outcomes to be assessed. Performance status has been proposed as a useful indicator of a patient's overall fitness and thus plays an important role in allowing discriminatory risk adjustment.