

West of Scotland Cancer Network

**Head & Neck Cancer
Managed Clinical Network**



Audit Report

Report of the 2010 Clinical Audit Data

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Executive Summary

Introduction

This report presents analysis results for the assessment of performance of head and neck cancer services in the West of Scotland (WoS), using clinical audit data from the period January – December 2010. It contains relevant audit data and an overview of activity and sets out action required in response to variance across the region.

The West of Scotland Cancer Network (WoSCAN) Head and Neck Cancer Managed Clinical Network (MCN) has been in existence for a decade and continues to benefit from the enthusiastic engagement of a range of healthcare professionals and managers involved in the delivery and development of services for head and neck cancer patients across the region.

Background

Head and neck cancer is the sixth most common cancer in Scotland, with approximately 5.4% of male cancer patients and 2.5% of female cancer patients affected. Approximately 1200 new cases are diagnosed per annum in Scotland.

The incidence in females continues to rise with a 3% increase over the last 10 years; whereas in males incidence has decreased by around 5.6% over the same time period. One year survival in head and neck cancer patients is approximately 78% with no difference between sexes, with 5-year survival marginally higher in females than in males at 62% and 55% respectively. Survival rates are improving, with a median survival time following diagnosis in the period 1988 – 1992 of approximately 4 years, which increased to 6.5 years during the period 2003 – 2007.⁽¹⁾

Head and neck cancer services in the WoS are organised around three MDTs serving 2.4 million people in four Health Boards – NHS Ayrshire & Arran, NHS Forth Valley, NHS Greater Glasgow and Clyde, and NHS Lanarkshire. During 2010 a total of 592 patients were diagnosed with head and neck cancer in the WoS.

Methodology

Audit staff in each WoS Health Board are responsible for collecting data on patients diagnosed by their service and entering that data on eCASE (electronic Cancer Audit Support Environment). The data is extracted from eCASE and analysed centrally by the WoSCAN Information Team. Analysis of the 2010 data against regionally agreed outcome measures was undertaken to assess the performance of each NHS Board individually and also produce a collated report allowing for full comparison of performance and volume of activity across the region.

Results

Regional analysis was carried out in order to assess performance against nine Key Outcome Measures (KOMs) which were developed and agreed by the MCN during 2011. The values below represent the WoS result, and range across Health Boards is expressed as a percentage.

1. All patients should be discussed by a multidisciplinary team prior to definitive treatment. (80.3[45.1 - 95.4]%)
2. Patients with head and neck cancer should have a histological diagnosis. (98.1[92.7 - 100]%)
3. Patients with head and neck cancer should undergo CT of the chest prior to first treatment. (82.5[66.7 – 94.0]%)
4. Patients diagnosed with head and neck cancer should be seen by a dietician (26.1[3.4 – 66.7]%).
5. Patients receiving surgery or chemoradiation treatment to larynx, oral cavity, oropharynx or hypopharynx should be seen by a speech and language therapist pre-treatment. (18.3[0.0 – 73.1]%)
6. Involved margins for patients undergoing curative surgery. (7.1[0.0 – 21.4]%)

7. 30 day mortality rate following final head and neck cancer surgery. (0.9[0.0 – 3.1]%)
8. 30 day mortality rate following final radiotherapy. (2.6[0.0 – 4.5]%)
9. Gaps in Radiotherapy Treatment (insufficient data available to assess performance against this measure).

Conclusions and Action Required

The Head and Neck Cancer MCN are encouraged by the performance of individual units against the regionally agreed KOMs introduced for the analysis of 2010 audit data. The results presented in this report demonstrate that patients with head and neck cancer in the WoS receive a consistent and improving standard of care, across all geographical locations.

Although the results are indicative of good quality service across the region, each MDT is responsible for taking action on the recommendations of the report locally. MDTs are required to assess their performance in the context of the WoS as a whole, identifying areas for improvement and investigating potential reasons for variation in performance.

Action Required:

- All MDTs should continue to be encouraged to retain the high level of performance status recording that is evident this year.
- All MDTs to continue to ensure that MDT discussion is documented and date of discussion is recorded to enable accurate assessment of the proportion of patients discussed prior to definitive treatment.
- Specific issues with regards to the recording of performance status data and MDT dates in NHS Ayrshire & Arran should be investigated further to facilitate improved data capture. (Completion of amalgamation of the NHS Ayrshire and Arran MDT with the North Glasgow MDT in early 2011 may have already resolved this).
- MDTs should ensure that all patients undergo chest CT *prior* to treatment to help inform the development of an appropriate treatment plan.
- All NHS Greater Glasgow and Clyde teams should ensure that dietetics and speech and language members document all interactions with patients and liaise with local audit staff, to improve data capture and facilitate accurate assessment of performance in relation to dietetic and speech therapy support.
- To enable consistent and specific recording in respect of margin involvement, all pathological teams should ensure that pathology reports are standardised to state *Margin Positive, Margin Clear, or Not Applicable*.
- Efforts should be made to compare 30 day mortality following final surgery for head and neck cancer across all 3 Regional Cancer Networks in Scotland at the forthcoming National Head and Neck Education Meeting scheduled for 2012.
- MCN to work with BWoSCC to develop a robust methodology for assessing gaps in radiotherapy treatment for head and neck cancer patients.

1. Introduction

This report presents analysis results for the assessment of performance of head and neck cancer services in the West of Scotland (WoS), using clinical audit data from the period January – December 2010. It contains relevant audit data and an overview of activity and sets out action required in response to variance across the region.

The West of Scotland Cancer Network (WoSCAN) Head and Neck Cancer Managed Clinical Network (MCN) has been in existence for a decade and continues to support the delivery and development of the service for head and neck cancer patients each year across three Multidisciplinary Team Meetings (MDTM). The Network continues to benefit from enthusiastic engagement of a range of healthcare professionals and managers across the region.

2. Background

Head and neck cancer patients usually present via an Ear, Nose and Throat clinic on a referral from their general practitioner, or from other secondary or tertiary care agencies.

Head and neck cancer services in the WoS are organised around three MDTs serving 2.4 million people in four Health Boards – NHS Ayrshire & Arran, NHS Forth Valley, NHS Greater Glasgow and Clyde (GGC), and NHS Lanarkshire. During 2010 a total of 592 patients were diagnosed with head and neck cancer in the WoS.

Table 1 lists MDTs by Health Board area, and includes the analysis group based on location of diagnosis, which has been used to present results throughout the report. As approximately 60% of cases diagnosed each year are managed in the NHS GGC area, analysis of data for this Health Board is broken down and presented in the following geographical groups – Clyde, North Glasgow and South Glasgow.

Table 1: Head and neck cancer MDT configuration in the WoS

MDT	Analysis Group (location of diagnosis)	NHS Board Area
Lanarkshire /Forth Valley	Lanarkshire (LS) Forth Valley (FV)	NHS Lanarkshire NHS Forth Valley
North Glasgow & Ayrshire	North Glasgow (NG) Ayrshire & Arran (AA)	NHS Greater Glasgow & Clyde NHS Ayrshire & Arran
South Glasgow & Clyde	South Glasgow (SG) Clyde (Clyde)	NHS Greater Glasgow & Clyde

2.1 National Context

Head and neck cancer is the sixth most common cancer in Scotland (3.9% of all cancers), with approximately 1200 new cases diagnosed each year. Nationally head and neck cancer affects approximately 5.4% of male cancer patients and 2.5% of female cancer patients. Incidence in females continues to rise with an approximate increase of 3% over the last 10 years; whereas in males incidence has decreased by around 5.6% over the same time period. The lifetime risk of developing head and neck cancer is estimated to be 1 in 48 for males and 1 in 118 for females.

Data shows that for head and neck cancer patients diagnosed between 2003 – 2007, 1 year relative survival was 78% with no differences between the sexes. Five year relative survival is marginally higher in females than males at 59.5% and 55.4% respectively. ⁽¹⁾

2.2 West of Scotland Context

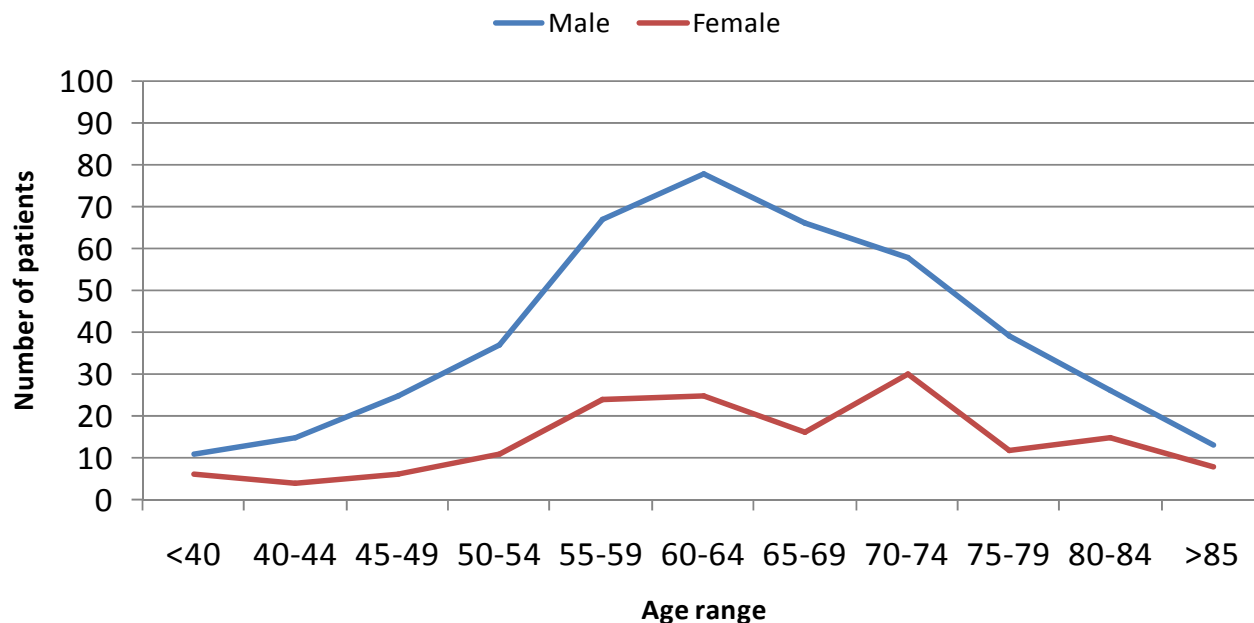
Head and neck cancer patients in Scotland have relatively poor outcomes compared with other countries. Available data suggests that poor overall survival for Scottish head and neck cancer patients is related to the advanced stage of disease at the time of presentation together with social deprivation. ⁽²⁾

The WoSCAN catchment area takes in some of the worst areas of socio-economic deprivation in the country ⁽³⁾, and the overall life expectancy for specific postcode areas is lower than any other area in the United Kingdom. This high index of deprivation is coupled with above average levels of smoking and alcohol use. With this in mind, the importance of an outcome focussed audit and action in response to audit findings is clear.

2.3 Age Distribution

Figure 1 illustrates the distribution of head and neck cancer cases by age group and gender. The occurrence of head and neck cancer is higher in males (73.5% of cases) than in females (26.5% of cases).

Figure 1: Age/sex distribution of head and neck cancer patients within WoS



Head and neck cancer continues to be more prevalent in patients aged 60 and over with around 65% of the total cases diagnosed in 2010 occurring in patients within this age group. The age distribution of WoSCAN cases is not significantly different from the demography of the rest of the UK. ⁽⁴⁾

2.4 Case Ascertainment by Health Board of Diagnosis

Capturing data on the total incident population (or as near as possible to that total) in each organisation is central to the validity of the audit findings. Assessment of population completeness for each Health Board is calculated by comparing the number of new cases identified by the audit against the 5 year average (2004-2008) of cancer registry incidence data. Table 2 illustrates the case ascertainment by Health Board for 2010 and demonstrates good case completeness across all boards, giving confidence in the reliability of results.

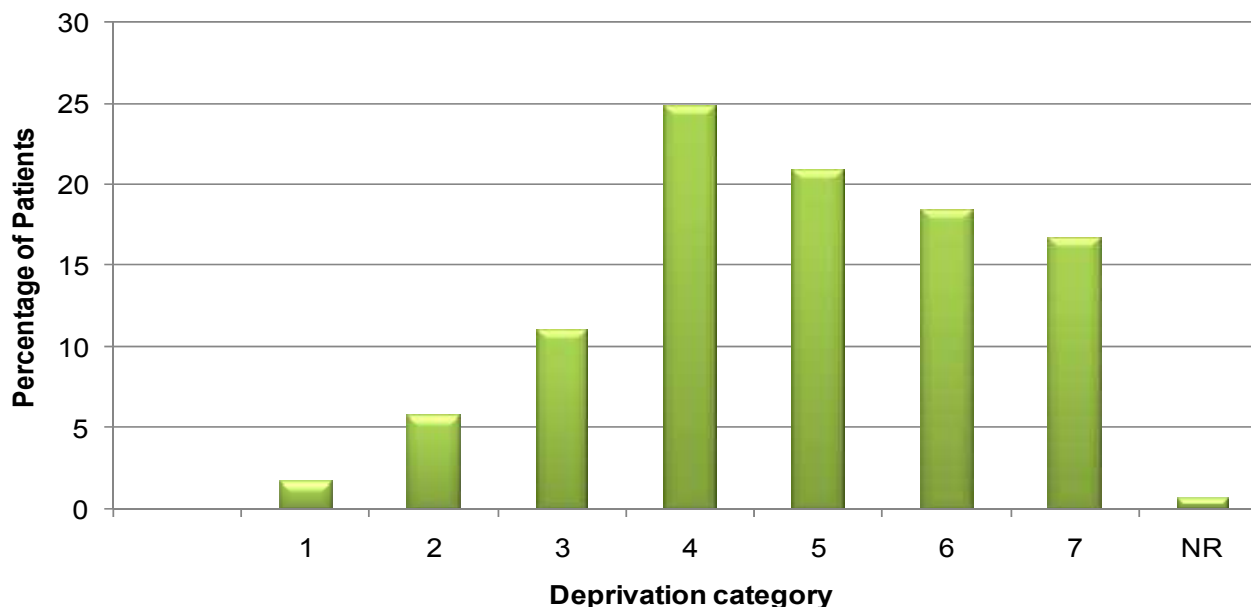
Table 2: Case ascertainment by Health Board

NHS Board	Cases from Audit	Cancer Registry Average*	Estimated Case Ascertainment (%)
Ayrshire & Arran	82	72	113.9%
Forth Valley	60	48	125.0%
Lanarkshire	93	89	104.5%
Greater Glasgow & Clyde	357	337	105.9%
WoS	592	546	108.4%

* The number of patients diagnosed each year will naturally vary, therefore some Boards may report case ascertainment above 100% and others below. Case ascertainment is intended to be an indication rather than an exact measure.

2.5 Deprivation Category

Figure 2: Breakdown of cases by deprivation category



As displayed in Figure 2 head and neck cancer incidence continues to be more prevalent in moderate-high deprivation areas, with deprivation category 1 representing the least deprived and category 7 the most deprived areas.

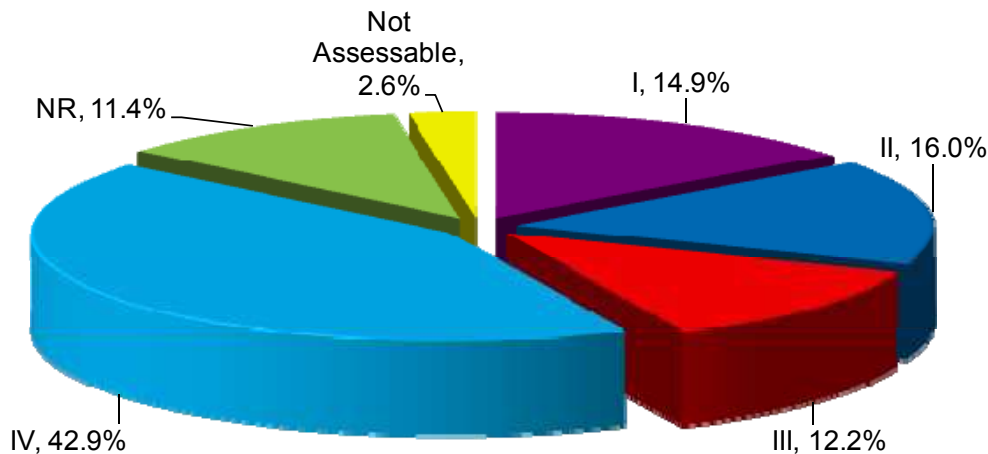
For future analysis a revised Scottish Index of Multiple Deprivation (SIMD) scale using a 5-stage categorisation rather than the above 7-stage categorisation will be utilised in line with Information Services Division (ISD) to enable national comparison.⁽⁵⁾

2.6 Stage at Diagnosis

Staging is the assessment of the extent of disease and is performed for prognostic and therapeutic purposes. TNM 7 staging was used to stage all head and neck cancers during 2010.

Analysis of stage in head and neck cancer patients was based on stage at diagnosis (pre-treatment). More than 55% of patients in the WoS presented with advanced stage disease (III or IV). The presentation of advanced stage disease increases demand on treatment capacity as most patients with advanced stage disease require multiple modes of treatment.

Figure 3: Stage distribution



2.7 Performance Status

Performance status (PS) is usually defined according to the five-point internationally agreed World Health Organization (WHO) scale.

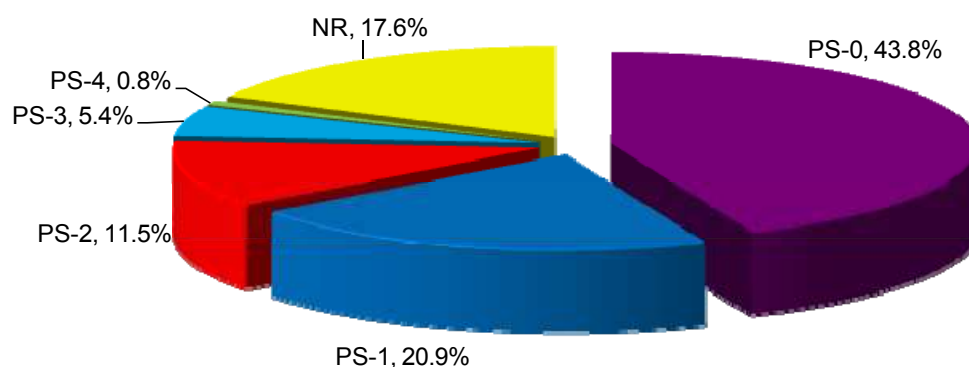
Table 3: WHO performance status definitions

Grade	Explanation of activity
0	Fully active, able to carry on all pre-disease performance without restriction.
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.
2	Ambulatory and capable of all self care but unable to carry out any work activities. Up and about more than 50% of waking hours.
3	Capable of only limited self care, confined to bed or chair more than 50% of waking hours.
4	Completely disabled. Cannot carry on any self care. Totally confined to bed or chair.

PS is not only an independent prognostic indicator but is an important determinant of treatment modality. For example, PS 4 patients are seldom treated with aggressive, radical treatments.

Figure 4 shows the distribution of WHO performance status for patients diagnosed with head and neck cancer in the WoS and indicates that the majority of patients are classified as PS grade 0 or 1.

Figure 4: Performance status distribution



3. Methodology

Within WoSCAN head and neck cancer data is collected in the four NHS Boards by Clinical Effectiveness Facilitators (CEFs). An agreed dataset is collected to enable the assessment of performance against regional Key Outcome Measures (KOMs).

The data collection cycle is over a 12 month period from 1st January to 31st December each year, with analysis of the data approximately 8 months following this to take account of the patient pathway and ensure that full treatment data is available. The data is collected locally by CEFs and entered into the electronic Cancer Audit Support Environment (eCASE), a secure centralised web-based database. Analysis is performed centrally by the WoSCAN Information Team and provisional audit reports are issued to each board to provide an opportunity for missing data or errors to be rectified before a final download of data is taken. Final reports are then issued to each Health Board and results are verified by the clinical lead for that area in line with the Regional Information Governance Framework.

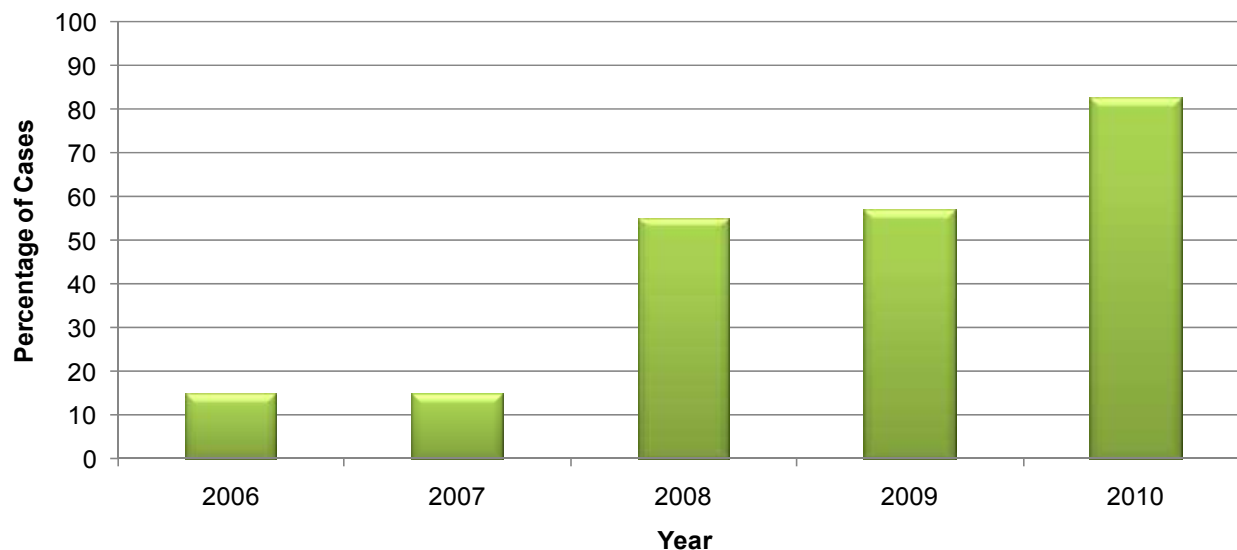
4. Results and Action Required

4.1 Data Quality

Data completeness rates for head and neck cancer data have improved in recent years, however a number of areas for data improvement have been highlighted in the appropriate sections of this report.

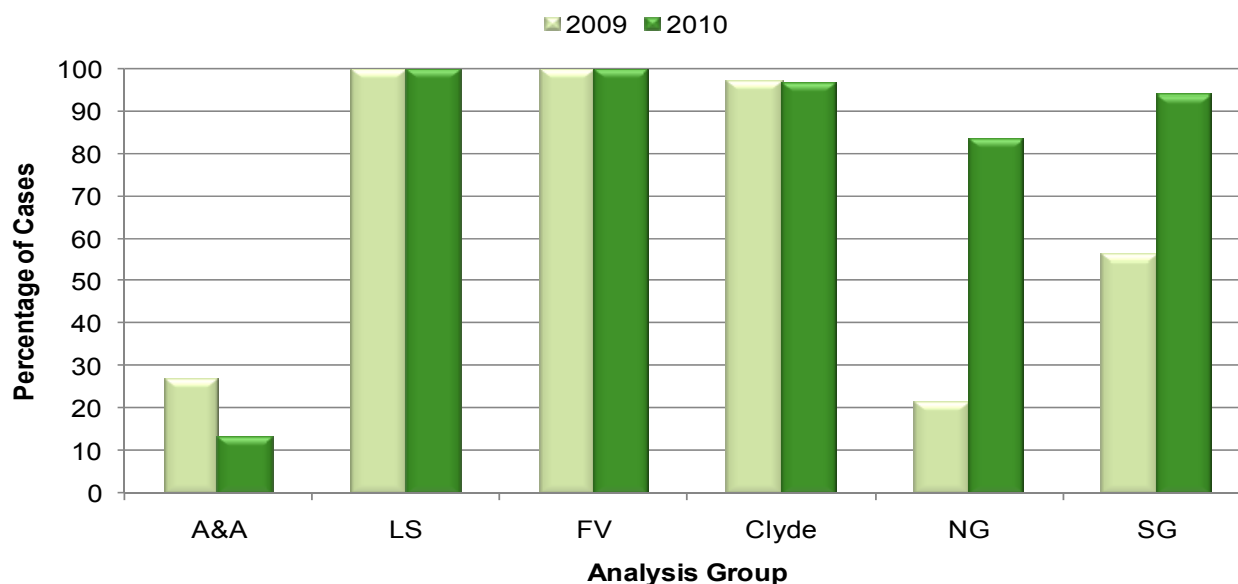
PS data capture is an area of clear improvement in the WoS with *not recorded* rates reducing from 85% in 2006 to only 18% in 2010. Rates of improvement are variable across the region which is suggestive of the potential to change processes at a local level to improve data quality. Figures 5 and 6 illustrate the significant improvement in data quality in relation to PS over time.

Figure 5: Annual performance status recording



Performance Status Recording by Analysis Group

Figure 6: Performance status recording by analysis group



	AA		LS		FV		Clyde		NG		SG	
	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010
N	26	11	93	93	42	60	62	59	32	102	71	163
D	97	82	93	93	42	60	64	61	149	122	126	174

Figure 6 illustrates the variance in data capture rates across the region with PS recorded in 100% of cases in Lanarkshire and Forth Valley in 2009 and 2010, significant improvement in North and South Glasgow and a reduction in recording of PS in Ayrshire and Arran from 26.8% in 2009 to 13.4% in 2010.

Action Required:

- Specific issues with regards to the recording of performance status in NHS Ayrshire and Arran should be explored to establish if this is a recording/reporting issue or a data collection issue and facilitate improved data capture.
- All MDTs should continue to be encouraged to retain this high level of performance status recording.

4.2 Performance Against Key Outcome Measures

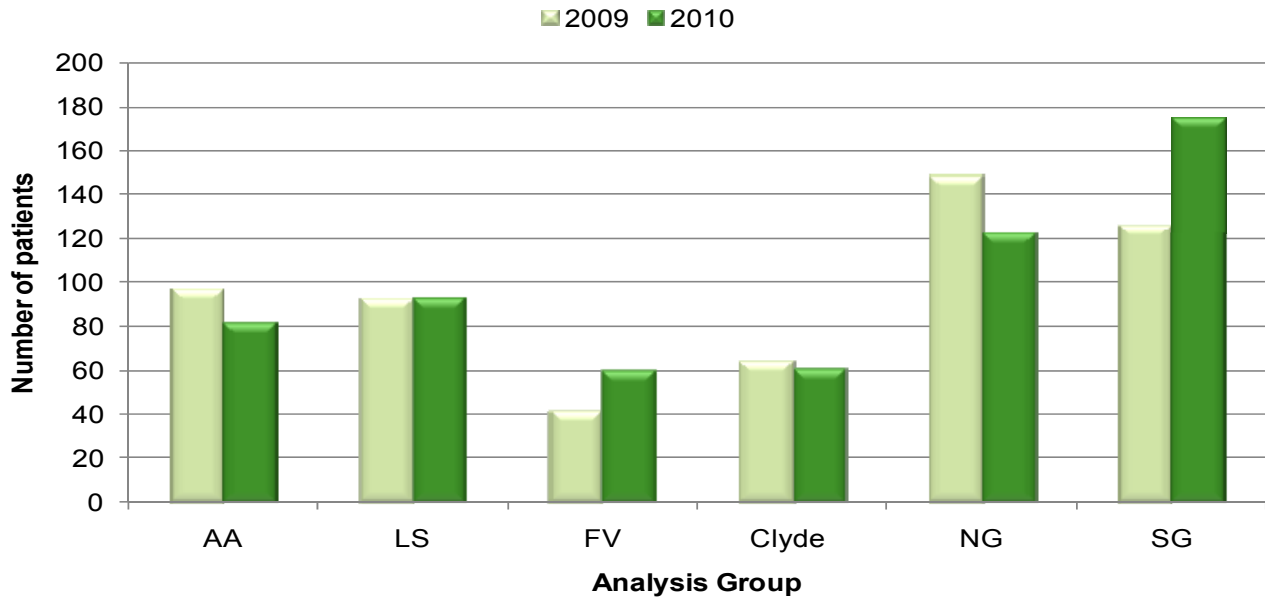
This disease group does not have Healthcare Improvement Scotland standards to report against. A core review group was established within the MCN to develop draft KOMs and realign the associated dataset to reduce the number of data items collected. The draft measures and a Regional Measurability Specification were circulated for wider consultation before the final measures were agreed regionally.

Results for each of the KOMs assessed are presented in graphical format with the underlying data also in tabular form. The data is presented in a combination of bar charts, pie charts and line graphs, with results displayed as a percentage of the overall number of cases where appropriate.

4.3 Results

There were 592 new diagnoses of head and neck cancer in the WoS during 2010. Figure 7 shows the distribution of cases across the region.

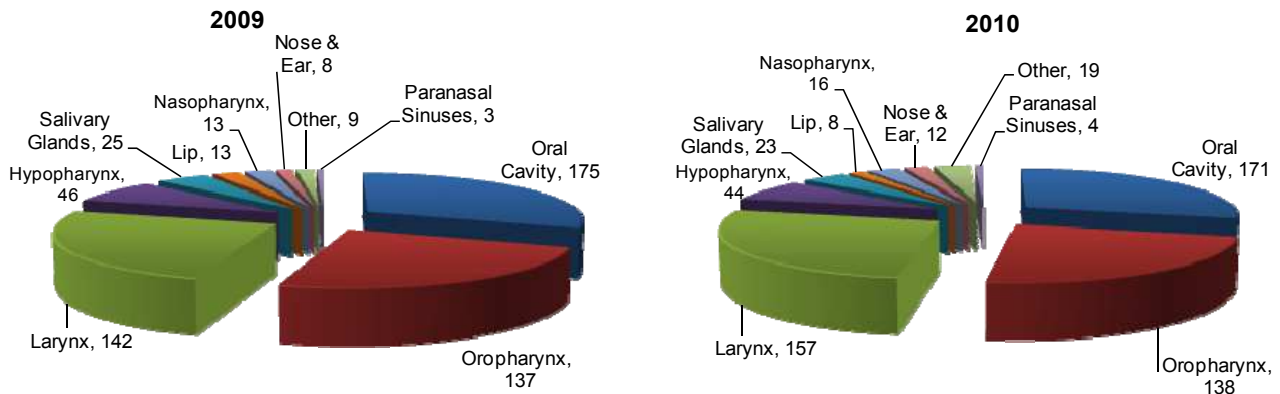
Figure 7: Distribution of head and neck cancer cases within WoS



	AA		LS		FV		Clyde		NG		SG	
	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010
N	97	82	93	93	42	60	64	61	149	122	126	174

Figure 8 displays the breakdown by cancer sub site and illustrates that in both 2009 and 2010 almost 80% of all new head and neck cancer cases were oral cavity, oropharynx and larynx cases.

Figure 8: Number of cases by sub site of disease

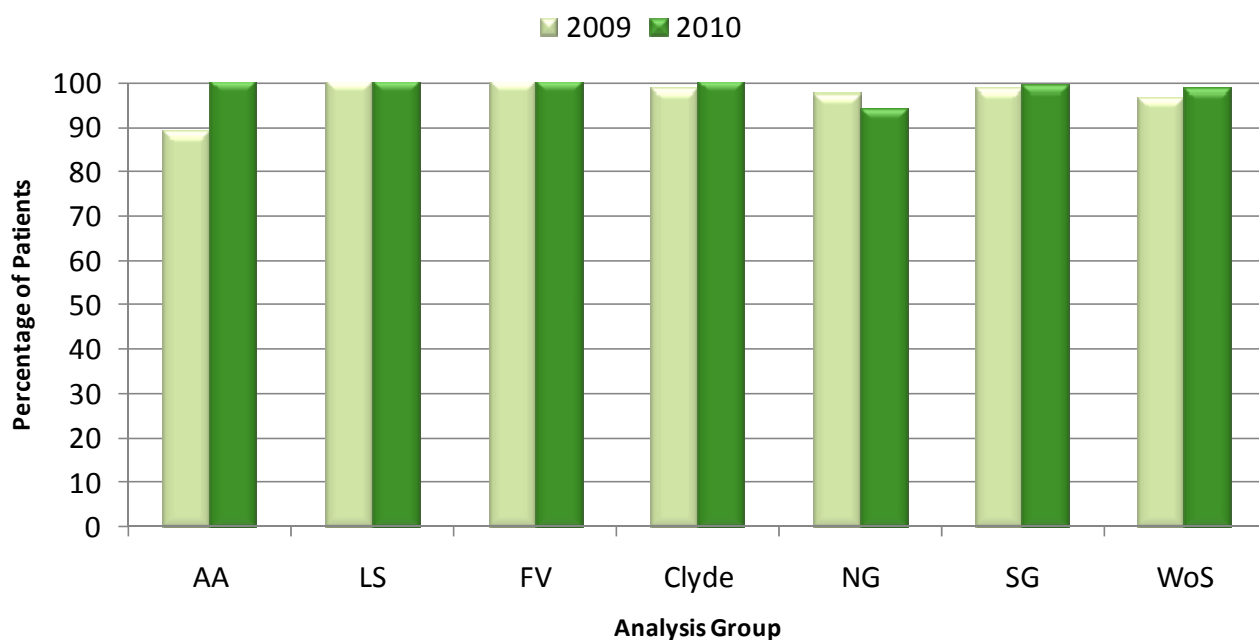


KOM 1: All patients should be discussed by a multidisciplinary team prior to definitive treatment

Evidence suggests that patients with cancer managed by a multi-disciplinary team have a better outcome and increased satisfaction. In addition, discussion prior to definitive treatment decisions being made provides reassurance that patients are being managed appropriately.

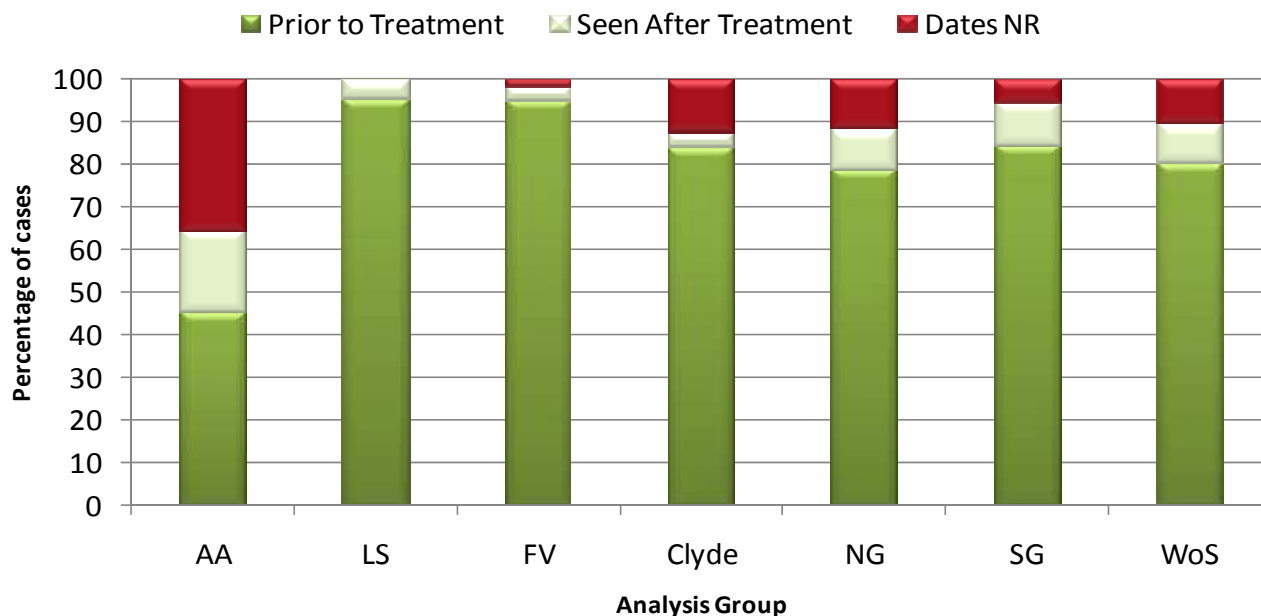
As displayed in Figure 9, the proportion of head and neck cancer patients discussed at MDTs in the WoS is extremely high with all but one team having 100% of patients discussed. The percentage of cases discussed prior to treatment and after treatment is illustrated in Figure 10.

Figure 9: Percentage of patients discussed at MDT



	AA		LS		FV		Clyde		NG		SG		WoS	
	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010	2009	2010
N	86	82	93	87	42	59	63	57	145	112	124	166	553	563
D	97	82	93	87	42	59	64	57	149	119	126	167	571	571

Figure 10: Percentage of patients discussed at MDT prior to treatment



	AA	LS	FV	Clyde	NG	SG	WoS
N	37	83	56	48	88	140	452
D	82	87	59	57	112	166	563

As illustrated in Figures 9 and 10, although a high proportion of patients are discussed at MDT, the percentage discussed *prior to treatment* varies across the region. Gaps in the recording of MDT discussion dates are evident, particularly for Ayrshire & Arran patients.

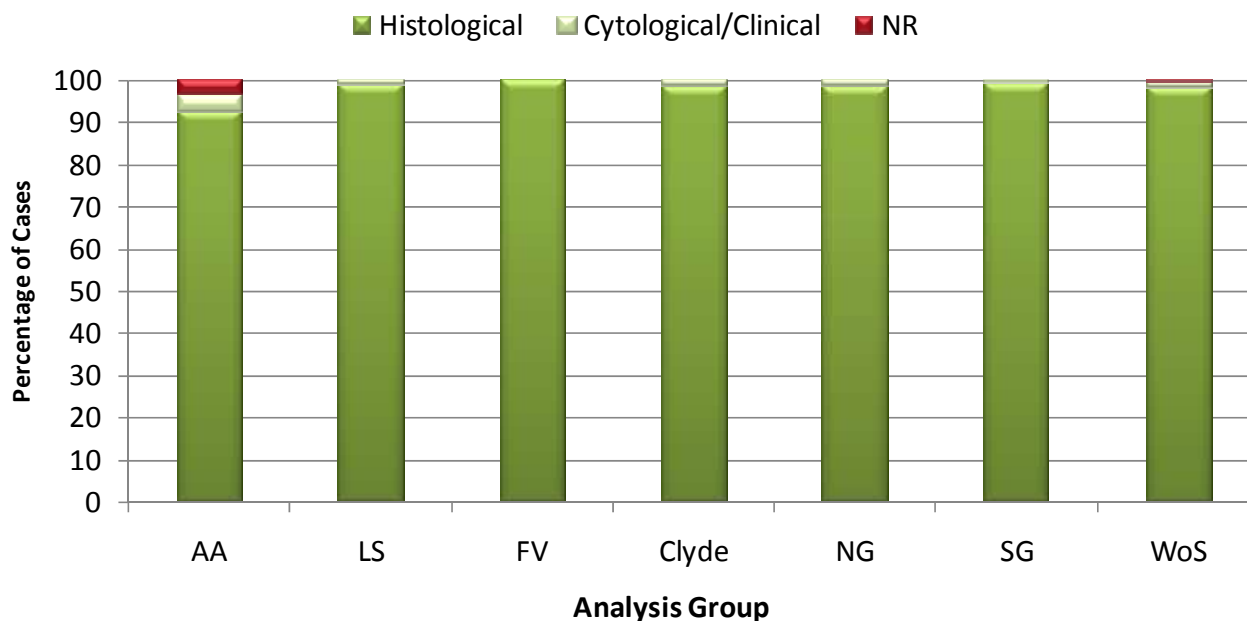
Action Required:

- a. All MDTs should continue to ensure that MDT discussion is documented and date of discussion is recorded to enable accurate assessment of performance against this measure.
- b. Specific issues in relation to the recording of MDT discussion dates in NHS Ayrshire & Arran should be explored further. (Completion of the amalgamation of the NHS Ayrshire & Arran MDT with the North Glasgow MDT may have already resolved this).

KOM 2: Patients with head and neck cancer should have a histological diagnosis

Although it is good practice to obtain a histological diagnosis of head and neck cancer, it is recognised that this is dependent on a number of clinical factors, and is not always possible or beneficial to the patient, due to the invasive nature of investigation and the attributes of the patient population. Figure 11 illustrates consistent performance across the region with a histological diagnosis obtained for the majority of patients.

Figure 11: Percentage of patients with a histological diagnosis



	AA	LS	FV	Clyde	NG	SG	WoS
N	76	92	60	60	120	173	581
D	82	93	60	61	122	174	592

KOM 3: Patients with head and neck cancer should undergo CT of the chest prior to first treatment

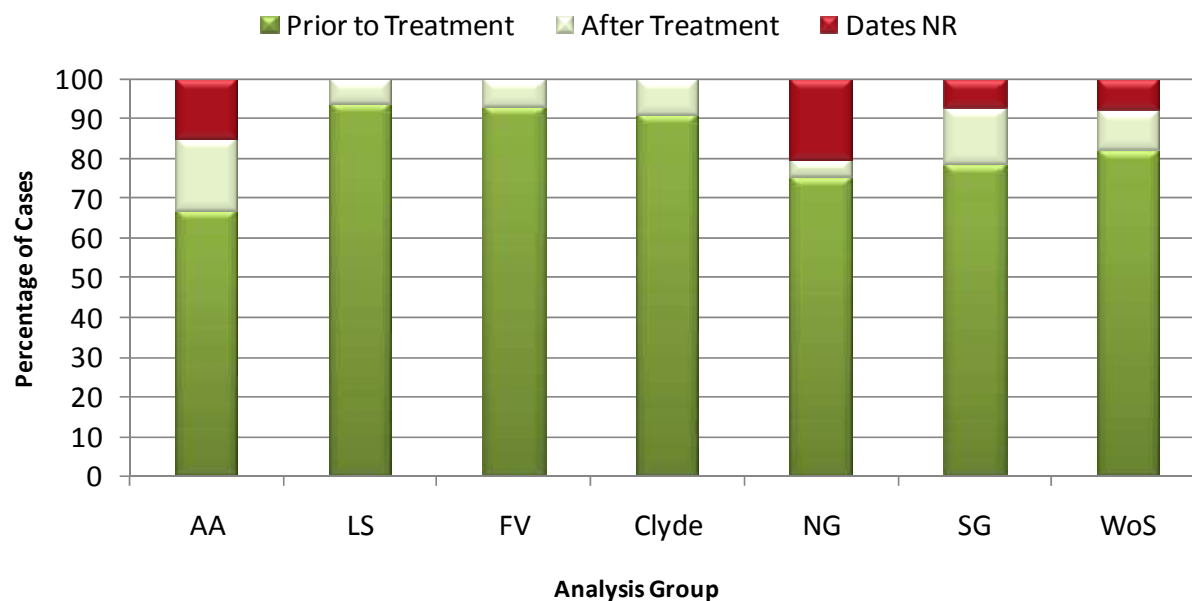
The detection of synchronous tumours, regardless of whether they are second primaries or distant metastases, in patients with head and neck cancer significantly affects prognosis and may alter management of the patient. CT scanning of the chest is an effective screening investigation in this group of patients, both in the detection of synchronous second primary tumours and for accurate staging of metastatic pulmonary disease.

Table 4 illustrates that the proportion of patients receiving CT of the chest ranges from 75.9-100% across the region.

Table 4: Number and percentage of patients receiving CT/X-Ray of the chest

Analysis Group	Receiving Chest CT/Xray		No Chest CT/Xray		Nr		Total
	n	%	n	%	n	%	
AA	60	75.9	16	20.3	3	3.8	79
LS	84	96.6	3	3.4	0	0.0	87
FV	60	100.0	0	0.0	0	0.0	60
Clyde	56	98.2	1	1.8	0	0.0	57
NG	92	77.3	24	20.2	3	2.5	119
SG	130	77.8	29	17.4	8	4.8	167
WoS	482	84.7	73	12.8	14	2.5	569

Figure 12: Percentage of patients receiving CT/X-Ray of the chest prior to first treatment



	AA	LS	FV	Clyde	NG	SG	WoS
N	40	79	55	51	64	102	391
D	60	84	59	56	85	130	474

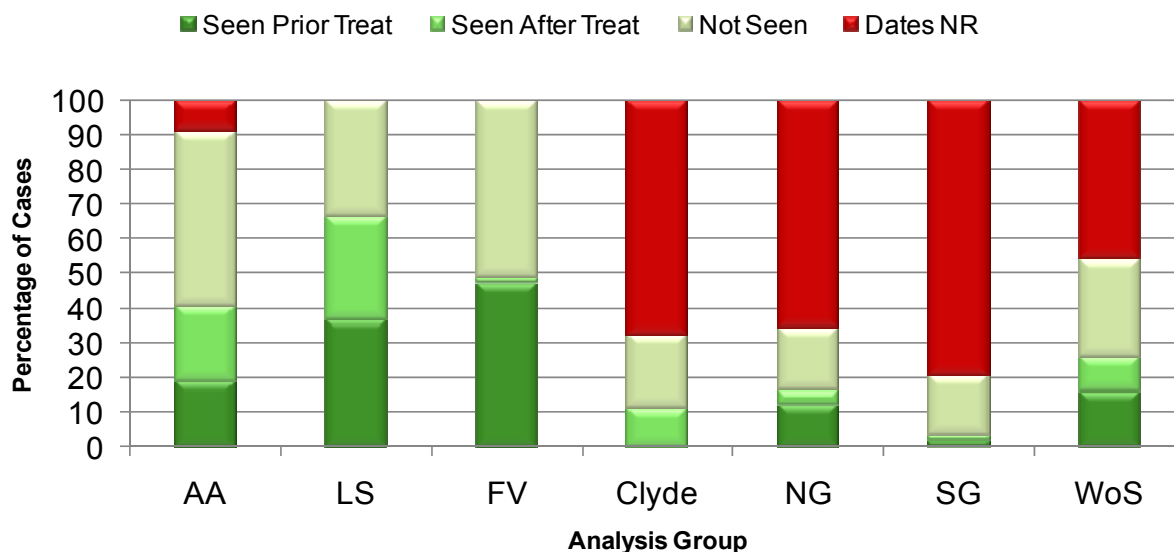
Figure 12 shows the percentage of patients receiving CT/X-Ray of the chest prior to first treatment and demonstrates that although there is a high performance rate against this measure, there is room for improvement with regards to the timing of the investigation.

Action Required:

MDTs should ensure that all of patients undergo chest CT *prior* to treatment to help inform the development of an appropriate treatment plan.

KOM 4: Patients diagnosed with head and neck cancer should be seen by a dietician

Figure 13: Percentage of patients seen by a dietician



	AA	LS	FV	Clyde	NG	SG	WoS
N	32	58	29	7	20	6	152
D	79	87	59	61	122	174	582

Dietetic support and assessment is important through all aspects of the patient pathway, particularly in those undergoing any form of treatment where the morbidity of the treatment can be reduced by appropriate intervention.

Data relating to whether patients have seen a dietician is universally poorly recorded across cancer types and Health Boards in the WoS. This is largely contributable to the fact that this information is often not documented in patient case notes. It has been demonstrated that liaison between audit staff and dieticians can lead to improvements in data capture however this is largely dependent on the co-operation and good record keeping of the dietician.

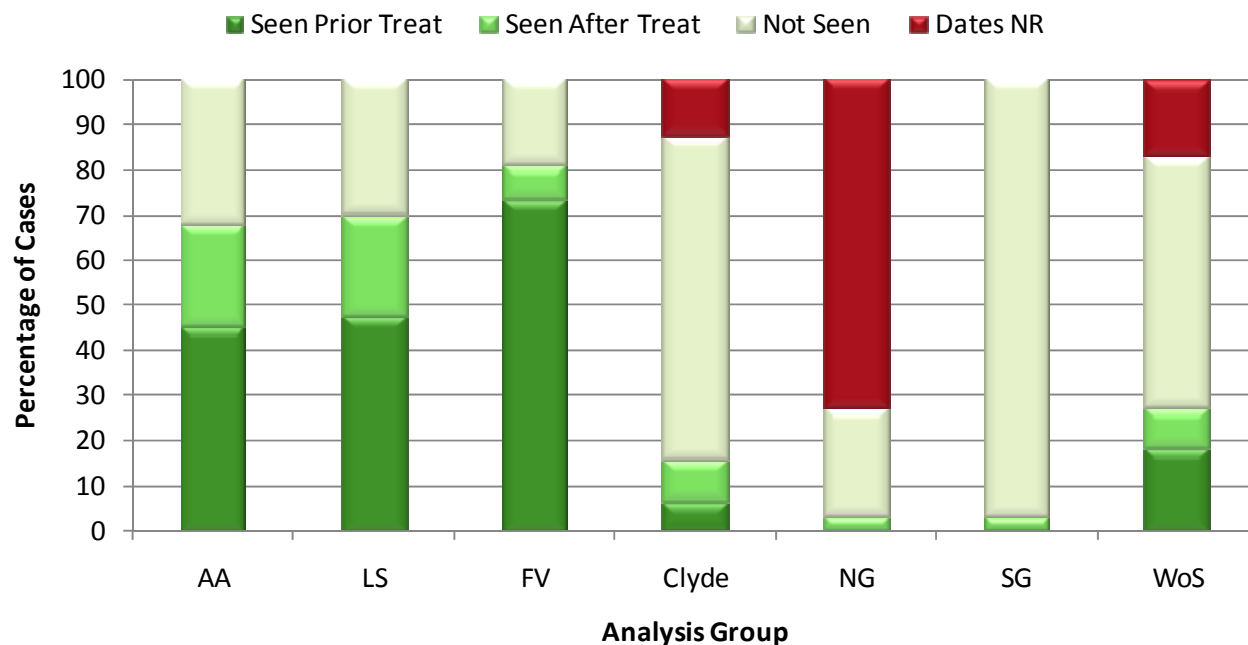
Figure 13 illustrates variation across the region with regards to dietetic input to patient care and the timing of this input in relation to treatment. In addition, gaps in the documentation of dietetic input across NHS GGC are evident from the high proportion of dates not recorded within the data.

Action Required:

All NHS GGC MDTs should ensure that dietetics members document all interactions with patients and liaise with local audit staff, to improve data capture and facilitate accurate assessment of performance against this measure.

KOM 5: Patients receiving surgery or chemoradiation treatment to larynx, oral cavity, oropharynx or hypopharynx should be seen by a speech and language therapist pre-treatment

Figure 14: Percentage of patients seen by a speech therapist



	AA	LS	FV	Clyde	NG	SG	WoS
N	14	19	19	2	0	0	54
D	31	40	26	32	63	103	295

Speech and language therapists have wide ranging roles in supporting patients with head and neck cancer. Their expertise and support is essential to patients whose cancer or treatment causes problems with communication or swallowing. Having comprehensive information available on surgical voice restoration provides the opportunity to give assurance to patients that appropriate speech and language support is being delivered.

Figure 14 demonstrates variation across the region, with a high proportion of patients managed by NHS GGC MDTs recorded as not having had contact with a speech and language therapist and a significant proportion of dates not recorded for North Glasgow patients. Feedback from MDTs suggests that the level of speech and language therapy input across the WoS is high, indicating a data recording issue rather than variation in practice.

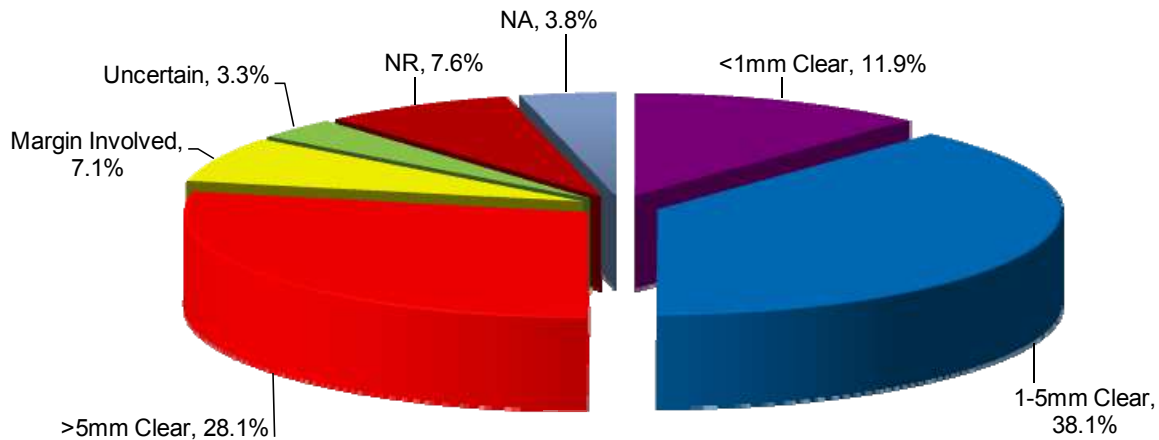
Action Required:

All NHS GGC teams should ensure that speech and language members record all patient interactions and liaise with local audit staff, to improve data capture and facilitate accurate assessment of performance against this measure.

KOM 6: Status of surgical margins

In order to reduce the risk of local recurrence patients undergoing curative surgery for head and neck cancer should have complete excision of involved margins.

Figure 15: Excision of margins



Across the region 7.1% of patients had involved margins following surgery, which is not unusual in a patient population where more than 50% of patients present with advanced stage disease. Figure 15 highlights inconsistencies in the recording/documentation of margin involvement with some surgical patients having either uncertain marginal involvement documented or no information recorded (NR) in relation to this data item. This is likely to be as a result of inconsistencies in the information contained within pathology reports.

Action Required:

To enable consistent and specific recording in respect of margin involvement, all pathological teams should ensure that pathology reports are standardised to state either *Margin Positive*, *Margin Clear*, or *Not Applicable*.

KOM 7: 30 Day mortality rate following final head and neck cancer surgery

This is the first year where mortality has been measured in relation to any aspect of head and neck cancer treatment in the WoS. Table 5 presents the 30 day mortality rate following final surgery for head and neck cancer for each Health Board and shows the overall WoS rate to be 0.9%. Differences in definition and measurement criteria prevent comparison with UK figures presented in the 2010 Data for Head and Neck Oncology (DAHNO) National Cancer Audit Report for England and Wales. ⁽⁴⁾

Table 5: Surgical 30 day mortality rate

Analysis Group	Number of Surgical Patients	Number Dying Within 30days of Final Surgery	Percentage (%)
AA	39	1	2.6%
LS	32	1	3.1%
FV	5	0	0.0%
Clyde	14	0	0.0%
NG	34	0	0.0%
SG	89	0	0.0%
WoS	213	2	0.9%

Action Required:

This important KOM should be used to compare WoS performance to other Head and Neck MCNs in Scotland at the forthcoming national Head and Neck Cancer Education Meeting scheduled for 2012.

KOM 8: 30 Day mortality rate following final radiotherapy

Radiotherapy 30 day mortality rate is calculated as death within 30 days of the date of completion of radiotherapy. Rates for the WoS are presented in Table 6. Subsequent year on year analysis of this KOM will enable the identification of trends and may highlight areas of variance across the region.

Table 6: Radiotherapy 30 day mortality rate

Analysis Group	Number of Radiotherapy Patients	Number Dying Within 30days of Final Radiotherapy	Percentage (%)
AA	35	1	2.9%
LS	54	2	3.7%
FV	22	1	4.5%
Clyde	35	0	0.0%
NG	77	3	3.9%
SG	86	1	1.2%
WoS	309	8	2.6%

KOM 9: Gaps in radiotherapy treatment

There was insufficient radiotherapy data available to WoS audit staff during 2010/11 to enable the assessment of performance against this measure.

A monthly download of radiotherapy data from the Beatson West of Scotland Cancer Centre (BWoSCC) was implemented during 2011 according to an agreed minimum dataset. This dataset does not contain sufficient detail to enable the identification of gaps in radiotherapy treatment however it is recognised that this KOM is core to the audit of MCN activity and alternative processes for capturing the necessary information are currently being explored.

Action Required:

MCN to continue work with the BWoSCC to develop a robust methodology for assessing gaps in radiotherapy treatment for head and neck cancer patients.

5. Conclusions

The Head and Neck Cancer MCN are encouraged that the majority of units have performed well against the regional outcome measures. The results presented in this report demonstrate that patients with head and neck cancer in the WoS continue to receive a consistent standard of care. We are encouraged by the introduction of KOMs, and are keen to be able to demonstrate continued progress against these measures over the next year. The MCN will actively take forward regional actions identified and Health Boards are asked to develop local Action/Improvement Plans in response to the findings presented in the report. Progress against these plans will be monitored by the MCN Advisory Board and reported to RCAG annually by Board Clinical Leads and MCN Lead Clinicians, as part of the regional governance process to enable RCAG to review and monitor regional improvement.

5.1 Action Required

- All MDTs should continue to be encouraged to retain the high level of performance status recording that is evident this year.
- All MDTs to continue to ensure that MDT discussion is documented and date of discussion is recorded to enable accurate assessment of the proportion of patients discussed prior to definitive treatment.
- Specific issues with regards to the recording of performance status data and MDT dates in NHS Ayrshire and Arran should be investigated further to facilitate improved data capture. (Completion of amalgamation of the NHS Ayrshire and Arran MDT with the North Glasgow MDT in early 2011 may have already resolved this).
- MDTs should ensure that all patients undergo chest CT *prior* to treatment to help inform the development of an appropriate treatment plan.
- All NHS GGC teams should ensure that dietetics and speech and language members document all interactions with patients and liaise with local audit staff, to improve data capture and facilitate accurate assessment of performance in relation to dietetic and speech therapy support.
- To enable consistent and specific recording in respect of margin involvement, all pathological teams should ensure that pathology reports are standardised to state *Margin Positive, Margin Clear, or Not Applicable*.
- Efforts should be made to compare 30 day mortality following final surgery for head and neck cancer across all 3 Regional Cancer Networks in Scotland at the forthcoming National Head and Neck Cancer Education Meeting scheduled for 2012.
- MCN to work with BWoSCC to develop a robust methodology for assessing gaps in radiotherapy treatment for head and neck cancer patients.

Acknowledgement

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- NHS Ayrshire & Arran
- NHS Forth Valley
- NHS Greater Glasgow and Clyde
- NHS Lanarkshire

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Abbreviations

AA	Ayrshire & Arran
AHPs	Allied Health Professionals
BWoSCC	Beatson West of Scotland Cancer Centre
CEFs	Clinical Effectiveness Facilitators
CT Scan	Computerised Tomography Scan
CNS	Clinical Nurse Specialist
DAHNO	Data for Head and Neck Oncology
eCASE	Electronic Cancer Audit Support Environment
FV	Forth Valley
ISD	Information Services Division
KOM	Key Outcome Measures
LS	Lanarkshire
MCN	Managed Clinical Network
MDT	Multidisciplinary Team
MDTM	Multidisciplinary Team Meeting
NG	North Glasgow
NHSGGC	NHS Greater Glasgow and Clyde
NOSCAN	North of Scotland Cancer Network
PS	Performance Status
PET	Positron Emission Tomography
SCAN	South East Scotland Cancer Network
SG	South Glasgow
SIMD	Scottish Index of Multiple Deprivation
WHO	World Health Organisation
WoS	West of Scotland
WoSCAN	West of Scotland Cancer Network

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