BRITISH ASSOCIATION OF HEAD & NECK ONCOLOGISTS

BAHNO STANDARDS 2009

BAHNO

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BACKGROUND TO THE BRITISH ASSOCIATION OF HEAD AND NECK ONCOLOGISTS

The association was first constituted in 1967 as the Association of Head and Neck Oncologists of Great Britain. The stimulus for its formation was the need to encourage discussion and the sharing of knowledge between the various clinical and research specialties involved in the management of head and neck cancer. Head and neck cancer is the generic term used for a group of malignant tumours that affect areas such as the face, mouth, jaws, sinuses, throat, larynx, salivary glands, thyroid gland and neck. Treatment is often complex and requires the cooperation of a number of medical, paramedical and nursing specialists. Although head and neck cancer is relatively uncommon in the UK (around 8000 new cases per year), it is the sixth most common cancer worldwide.

In 1995 our name was changed to the British Association of Head and Neck Oncologists (BAHNO). Although we have strong links with the relevant individual medical and paramedical specialty associations we are the only multi-disciplinary professional group which can speak for the interests of head and neck cancer clinicians and patients in the UK. We pursue our aims chiefly by holding regular scientific meetings and have produced important publications relating to the organisation of head and neck cancer services in the United Kingdom. BAHNO is affiliated to the International Federation of Head and Neck Oncologic Societies which links approximately 4300 clinicians worldwide.

Membership of BAHNO is open to all specialists with a major interest in head and neck oncology. Our members are principally:

- clinical oncologists (radiotherapists)
- otorhinolaryngologists (ear, nose and throat surgeons)
- oral and maxillofacial surgeons (mouth, jaw and face surgeons)
- plastic surgeons
- pathologists
- research scientists
- therapeutic radiographers
- specialist nurses
- speech and swallowing therapists

Currently we have approximately 340 members, including a number from overseas. Further details of BAHNO's aims and activities can be obtained by contacting the Honorary Administrative Secretary.

CONTACT DETAILS FOR BAHNO

BRITISH ASSOCIATION OF HEAD & NECK ONCOLOGISTS

www.bahno.org.uk

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INTRODUCTION TO BAHNO STANDARDS FOR THE PROCESS OF HEAD AND NECK CANCER CARE

Ten years ago, BAHNO published its document on Provision and Quality Assurance for Head and Neck Cancer, setting standards for the multidisciplinary care for patients with Head and Neck cancer. In 2002, we collaborated with the Royal College of Surgeons of England, the National Clinical Audit Support Programme and the Department of Health in the production of the National Comparative Audit based on the National Cancer Data Set module for head and neck cancer which had evolved and developed into the web-based national data collection tool, DAHNO.

In 2004 the National Institute for Clinical Excellence (NICE) issued Guidance on Improving Outcomes in Head and Neck Cancer, rightly emphasising the need for constant audit and data collection as the basis for improving standards of care.

I am delighted that BAHNO has once again been able to contribute to the continuing improvement of care for our patients by publishing these Standards for the Process of Head and Neck Cancer Care. The document covers all aspects of multidisciplinary care of the patient with head and neck cancer, and in addition lists the Top Ten Standards for use in both local and national audit.
I should like to thank Mr Richard Wight, Chair of the Audit Committee, Professor Martin Birchall, Chair of the 2008 Standards Committee and his committee members, Mr Graham Putnam, Dr Gerry Robertson, Sally Lane and our patient and carer representative Ethel Culling for all of their hard work in bringing this most important publication to the light of day.

Mr John Watkinson President of BAHNO
Dr Frances Calman Immediate Past President

USE OF THE STANDARDS IN CLINICAL AUDIT

The achievement by BAHNO in producing standards for the process of delivery of care in head and neck cancer in the United Kingdom is a key step along the road of improving the provision to head and neck cancer patients. Now that the standards are available the key challenge to professionals involved in the care pathway is to aspire and meet the standards in every department in the country and assure patients of their compliance. The route to this assurance is clinical audit.

For some of the standards local audit is the most effective tool for assessment, but for others network or national comparative audit better meets the requirements. A selection of standards will be reported in future National comparative audit (DAHNO) reports and can be found on page 19.

I encourage all BAHNO members and head and neck professionals to support these endeavours.

Mr Richard Wight BAHNO Audit Chair

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BAHNO STANDARDS FOR THE PROCESS OF HEAD AND NECK CANCER CARE

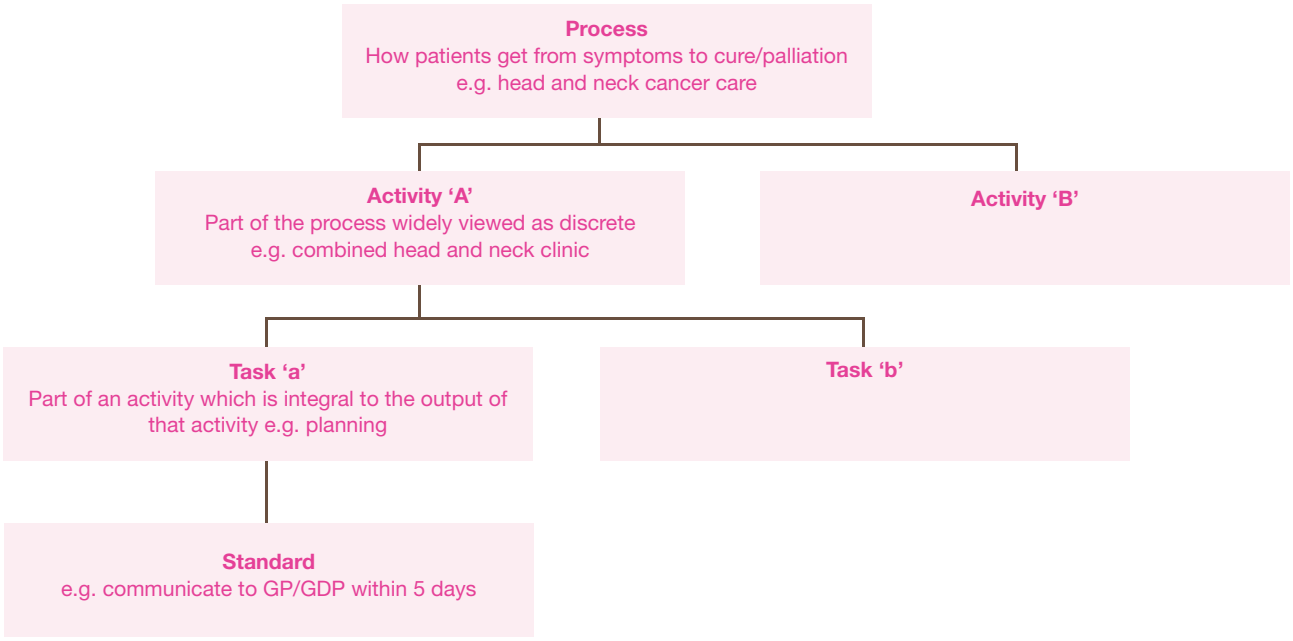
3.1 – Introduction

Health care standards allow the provision of a common set of requirements for care that apply across all health care organisations to ensure that health services are provided that are both safe and of an acceptable ('minimum high') quality. Second they provide a framework for continuous improvement in the overall quality of care people receive. The ability to monitor and measure the delivery of care against a peer derived standard will lead to the driving up of quality of care and provides an important quality assurance framework as well as governance.

3.2 – How the standards are presented

These are classified by activity area within the head and neck cancer process of care (Main text: Figure 4) and by task within each activity area. The model for the process adopted is given below, with an example of how the standards are presented.

Hierarchical model for the process of care



Example

The part of the patient care pathway addessed by each set of standards

The part of each activity addessed by a specific standard

Standard, including, where applicable, a figure for the minimum frequency (expressed as a percentage) with which the standard should be met compatible with a high standard of care

Activity	Task	Standard
First outpatient visit	**Consultation**	95% of patients to be seen by a consultant

3..3 – BAHNO Standards 2009

Activity	Task	Standard
All activities	**Co-ordination**	100% of Units / Centres should have a named head and neck specialist responsible for co-ordinating the local provision of care 100% of patients should be seen by a 100% specialist head and neck liaison nurse (e.g. Macmillan), whose contact details should be provided to all patients at the earliest opportunity in all cases. All patients will have a 'named key worker'. 100% of centres should have a list of consultants designated to provide head and neck cancer care at that centre.
Primary/Secondary Care Interface	**Referral to hospital**	100% of urgent referrals ('two-week wait') should adhere to National referral guidelines and include the alarm symptom or clinical finding, it should state a concern that these are due to an underlying head and neck malignancy and include relevant medical history, risk factors and medications Referral outside the urgent pathway particularly by routine mail should be discouraged but if unavoidable the same information is required. After following National guidelines, 100% of these should go to appropriate specialities: ENT (hoarseness, neck lumps) or oral & maxillofacial (oral ulcers/lesions, neck lumps) No patients with these presentations should go to general surgeons.
	Issuing of referral letters	Referrals should arrive at Trust cancer office within 24 hours of initiating the referral 100% should describe 'alarm symptoms' and risk factors and be labelled urgent 100% should describe the worry about cancer, psychosocial risk factors, background psychiatric history, and degree of social support
	Issuing of discharge summaries	90% Centres/Units should have a written protocol and or/checklist to include: * BRIEF overview of the inpatient care received * name and contact details of head and neck key worker for GP and patient/carers * diagnosis, procedures, complications with dates * follow-up arrangements 80% discharge summaries should arrive within four working days of discharge, preferably electronically.

Activity	Task	Standard
Information	**Documentation of patient and carer information 'bad news' consultation**	100% of patient notes should document what the patient and his/her carers have been told about the diagnosis, prognosis and treatment. All patients should be asked whether they wish to know the diagnosis, and if so, 100% should be told they have a cancer. Consultations should be conducted in accordance with King's Fund guidelines. Specialist head and neck liaison nurse to be present 90%. 80% clinical staff should be aware of these guidelines.
	Information about treatments	Two leaflets available in 100% head and neck clinics and wards: 1. a general one on head and neck cancer 2. a list of support organisations (national and local), and details of where to get extra information. One document on the list must be the current set of national standards in lay terms. Register of patients appropriately trained to visit should be maintained by the specialist liaison nurse and visits from such persons offered to all patients. 100% of Centres should have a computerised database containing the DAHNO minimum data-set. 95% of patients' entries must be updated a minimum of annually/until death. 100% of patients to be entered on this database, with 80% of fields completed.
Information technology		100% of such records to be forwarded electronically to DAHNO central database. 100% of host Trusts should provide funding for hardware, software, annual licenses and updates to maintain the above. All Trusts also to provide administrative support to collect and enter data.

Activity	Task	Standard
Interdisciplinary head and neck clinic	**Time-tabling**	These should be held weekly in each unit undertaking head and neck cancer treatment.
	Staffing	At least two appropriately trained Head and Neck surgeons (at least 50% of time devoted to head and neck oncology), one of whom should have specialist head and neck reconstructive skills. Present 100% of clinics Oncologist with a special interest (at least 50% of time devoted to head and neck oncology), Present 100% of clinics 100% of patients with palliative care needs should have access to their local team
	Treatment planning	Both a surgeon and an oncologist should be involved in the consultation and planning in 100% of cases The treatment plan should be formulated at the first MDM for 100% of patients that either delineates definitive treatment OR outlines necessary investigations leading to final treatment plan The team should use a written protocol and a bench-mark to manage co-ordinated care 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. 80% of plans should include actual dates of treatment start
	Patient selection	100% of patients with a new or recurrent head and neck cancer diagnosis should be discussed by an MDT prior to treatment, and this discussion should be documented

Activity	Task	Standard
In-patient care	**Nursing staffing**	Nurse in Charge on each shift should have a diploma or degree in a related discipline 2 other nurses on the staff should have or be preparing for a diploma or degree in related disciplines Nurses should be informed and aware of on-going audits and clinical trials
	Medical staffing	Higher advice at experienced specialist registrar AND consultant level available 24 hours a day every day
	Other staffing	Named dietician, physiotherapist, pharmacist, hygienist, psychologist and social worker 100% of patients should be seen by a dietician prior to the commencement of treatment
	Patient admissions	Patients should be provided with choice of admission date within 2 days of the head and neck clinic in 90% of cases documentation to be posted to patients should include: • name & location of ward & lifts • parking • contact details for key worker • information about personal possessions • visiting times • the names of the consultant & ward sister
	Team meeting	There should be a multidisciplinary discharge planning meeting on admission to include rehabilitation and social work considerations

Activity	Task	Standard
Operating theatres	**Staffing**	The senior nurse should have a degree or diploma in a related discipline Staff should include one other nurse with or studying for a degree or diploma in a related discipline
	Anaesthetics	There should be one or more named consultant anaesthetist(s) with an interest in head and neck operations responsible for directly or indirectly overseeing 100% of major head and neck operations.
	Provision of equipment	This should include: • A range of Hopkin's rod telescopes • laser (suitable for head and neck use) • microvascular kit; 2-headed microscope
	Time-tabling	There should be at least one three session day per week dedicated head and neck surgery operating list in host Trust Day-case list access should be available on-site

Activity	Task	Standard
Diagnosis and staging	**Responsibility**	95% of staging should be by a head and neck specialist, whoever is responsible for the initial diagnosis
	Examination under anaesthesia (EUA)	TNM staging in 100% (includes TxNxMx) 90% EUA and panendoscopy for all laryngopharyngeal tumours
	Radiology	A standard imaging protocol should be applied Images should be reported by radiologists with special expertise in head and neck radiology (i.e. one to three who together report on more than 75% of head and neck radiology for that centre) 90% of radiology should be reported prior to commencement of treatment 75% CT scans should adhere to published R.C.R. protocols Imaging of chest in 95% of cases prior to treatment planning. CT/MRI 90% tumours at all sites (except lip) and 100% of nose/sinus/ear tumours OPG 100% patients (irrespective of primary site)
	Biopsy	100% of new cases require a histological diagnosis of cancer prior to treatment planning
	Fine-needle aspiration cytology	100% of parotid masses 100% undiagnosed neck masses Interpretation by a named cytologist with a head and neck interest.
Pathology	**Reporting**	100% of cases should have completion of the national dataset for head and neck carcinoma histopathology reports 80% of FNA's reported on same day as taken

Activity	Task	Standard
Primary therapy	**Surgery**	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
	Outcome	30 day and 2 year relative survival to be recorded in 98% of patients 100% administered according to Quality Assurance in Radiotherapy (QART)
Radiotherapy	**Quality**	100% reporting according to ICRU 50 95% recording of early and late toxicity using validated scoring system 100% on linear accelerator machines
	Timing	With curative intent 50% to start within 2 weeks of decision to treat and 100% within four weeks . With palliative intent 50% to start wthin 48 hours, and 100% within 2 weeks Surgery to post-operative radiotherapy 42 days 90% courses without unplanned breaks All unplanned breaks managed according to RCR criteria
Chemotherapy	**Regimens**	100% of centres to have written protocols for different tumour sites and intents, these to be regularly updated in the light of research trial evidence at least every two years.
	Regimens	Evidence-based guidelines for the use of chemoradiotherapy should be present in 100% of units.
	Compliance	Use outside trials should be 90% compliant with the above protocols.
	Timeliness	The start of chemoradiation will usually be determined by the availability of radiotherapy. However, palliative sole modality treatment should start within one week in 90% of cases.

Activity	Task	Standard
Reconstruction	**Provision of techniques**	A range of reconstructive options must be available to include soft tissue and composite free flaps Free flap failure rate should not be greater than 10%
	Provision of facilities	Theatre as above 100% availability of HDU and ITU in the same building 100% should have a written protocol for postoperative flap care
Dental and prosthodontic care	**General dental care**	80% of Centres and Units should provide retained surgical prostheses 100% patients should be assessed by a suitably qualified dental practitioner before and after their main treatment
	Pre-treatment assessment and treatment	A suitably qualified practitioner should assess all patients possibly requiring orbital, nasal and auricular prostheses pre-operatively 100% of patients having head and neck radiotherapy should see a dental hygienist, and 100% of dentate patients should be prescribed fluoride mouthwashes
	Attention during radiotherapy	75% should see a hygienist 90% should be prescribed fluoride mouthwashes

Activity	Task	Standard
Rehabilitation of speech and swallowing	**Staffing**	100% of centres/units should have a named speech therapist with at least 50% of time dedicated to head and neck cancer work and with specialist surgical voice restoration skills 100% of patients for surgery or chemoradiation treatment to larynx, oral cavity, oropharynx or hypopharynx to be seen by specialist speech and language therapist pre-treatment and as required thereafter.
	Video-fluoroscopy	Facilities should exist in 100% of centres. A speech and swallowing therapist should be present at 100% of examinations.
Follow-up	**Outpatient review**	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.

Activity	Task	Standard
Research and audit	**Clinical trials**	All centres should be recruiting to at least one NCRN-registered national head and neck cancer trial. Recruitment to clinical trials and notification to local NCRN office should take place as part of the treatment-planning process, with same 3-day standard. 90% of eligible patients should be invited to participate
	Clinical audit	There should be 100% participation in process and outcome audit, with at least one active head and neck project at all times Participation in DAHNO national head and neck audit in 100% of centres. The results of audit (local and national) should be publicly available

Activity	Task	Standard
Psychological care	**Assessment**	A well-validated psychological tool should be used for screening all patients for need
	Personnel	90% of permanent medical, nursing and paramedical staff should be aware of written protocols and referral routes In 100% of teams an appropriately skilled clinical nurse specialist should be the primary point of intervention. In 100% of teams a psychologist with a head and neck interest (occupying 25% of job plan) should be a team member
Addiction support	**Counselling**	100% of smokers and those with alcohol dependency should be offered local addiction/smoking cessation support pre-treatment.

Activity	Task	Standard
Palliative care medicine	**Hospital medical and nursing staffing**	All centres to have written guidelines agreed with the local palliative care consultant(s) Amongst permanent staff, there should be: • 100% awareness of protocols for cancer pain management (WHO, EAPC) • 100% awareness of the existence of neuropathic pain • 100% knowledge of route of referral to palliative care (person, place, method)
	Crisis planning	100% of centres and hospices dealing with head and neck cancer patients should adhere to BAHNON guidelines for tracheostomy blockage and major vessel 'blow-out'. 90% of ward nurses should know these protocols patients at risk of these crises and their carers should be made aware of the warning signs in 100% of cases
	Living with cancer	90% of MDT staff should be aware of the Liverpool Care of the Dying pathway
	Notification of death	For patients dying in hospital, the patient's GP should be informed within one working day of the death in 100% of cases. For patients dying at home or in a hospice, the patient's Consultant should be informed of the date and location of death within 10 working days in 80% of cases

3.4 – Summary of minimum standards for intervals between activities in the process of head and neck cancer care (calender days)

Time between activities	Standard
Overall time	100% of patients to be commence treatment within 62 days of GP referral
General practitioner / dental practitioner referral date to first outpatients visit	14 days
Clinic correspondence to general practitioner / general dental practitioner	7 days from clinic attendance
Biopsy arrival in pathology department	Within 24 hours
FNA reporting	80% same day
Time for frozen section result	30 minutes for one, 45 for multiple
General clinic to examination under anaesthesia/ panendoscopy/ dental and prosthetic assessments	7 days
Biopsy to report issue	90% by 7 days
Surgical resection to reporting	80% by 14 days (21 if decalcification required)
General clinic to multidisciplinary team meeting (MDTM)	14 days
Decision to treat to radiotherapy, chemotherapy (curative intent)	31 days to start radiotherapy 21 days to start of chemotherapy
Decision to treat to radiotherapy, chemotherapy (palliative intent)	14 days
MDTM to ablative surgery from decision to treat	31 days
Surgery to post-operative radiotherapy	42 days
Primary treatment to rehabilitation (speech, swallowing, needs assessment)	No delay
Completion treatment to first follow-up clinic	One month

3.5 – "Top Ten Clinical Standards" for national comparitive audit and additional supporting information technology standards

Activity	Task	Standard
All activities	**Co-ordination**	100% of patients should be seen by a 100% specialist head and neck liaison nurse (e.g. Macmillan), whose contact details should be provided to all patients at the earliest opportunity in all cases.
	'Bad news' consultation	Specialist head and neck liaison nurse to be present 90%.
Treatment	**Treatment planning**	The aim of treatment (cure/palliation) should be documented at the first combined clinic in 80% of cases.
	Radiology	CT/MRI 90% tumours at all sites (except lip) and 100% of nose/ sinus/ear tumours
Primary therapy	**Surgery**	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
	Staffing	100% of patients should be seen by a dietician prior to the commencement of treatment
	Outcome	30 day and 2 year relative survival to be recorded in 98% of patients
Radiotherapy	**Timing**	90% curative intent to start within 28 days of decision to treat
Rehabilitation of speech and swallowing	**Staffing**	100% of patients for surgery or chemoradiation treatment to larynx, oral cavity, oropharynx or hypopharynx to be seen by specialist speech and language therapist pre-treatment and regularly thereafter.
Research and audit	**Clinical trials**	All centres should secure ethical permission, R&D approval and recruit to at least one NCRN-registered national head and neck cancer trial, except where site specific issues preclude participation.
Information technology		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. 100% of patients to be entered on this database, with 80% of fields completed.

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BAHNO STANDARDS AND USE IN NATIONAL COMPARATIVE AUDIT IN ENGLAND AND WALES (DAHNO)

The fourth annual National comparative audit report expected at the end of March 2009 will utilise the standards identified above to compare current performance and provide a baseline of achievement across England and Wales. These will be reported on a named trust basis and reassessed on a yearly basis seeking to demonstrate rising levels of compliance with the standards by complete audit cycles.

The two information technology standards relate to DAHNO submissions and levels of expected compliance in England and Wales. In Wales submission is via Cancer Network Information System Cymru (CaNISC) and subsequent upload to DAHNO.

Further standards will be reviewed by the DAHNO head and neck clinical reference group for potential inclusion in future collection years.

More information on DAHNO can be found at:-
http://www.ic.nhs.uk/our-services/improving-patient-care/national-clinical-audit-support-programme-ncasp/cancer/head-and-neck

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ACKNOWLEDGEMENTS AND LIST OF CONTRIBUTORS TO BAHNO WORKING GROUP AND SOUTH WEST WORKING GROUP

BAHNO wishes to thank the NHS Information Centre for health and social care for its support in facilitating the working group meetings that led to the production of the 2009 standards

BAHNO is indebted to its members who generously donated their time to contribute to the working group and in particular Professor Martin Birchall who chaired the group.

BAHNO recognises the foundations to this work that arose from the South West Head and Neck group who formulated a series of iterations of standards published in 2000, 2001, 2005.

Members in Wales may also wish to consider standards produced by the Cancer Services Co-ordinating group produced in 2005

Members of BAHNO standards 2009 working group :-

Professor Martin Birchall (ENT, Bristol) Chair
Mr Graham Putnam(OMFS, Carlisle)
Dr Gerry Robertson (Radiotherapy/Oncology, Glasgow)
Sally Lane (Specialist Nursing, Aintree)
Ethel Culling (Patient and Carer Representative, Newcastle)

Birchall, M. A., Bailey, D., & Lennon, A. Performance and standards for the process of head and neck cancer care; South and West audit of head and neck cancer 1996-1997 (SWAHN I) South and West Regional Cancer Organisation, Tumour panel for head and neck cancer. Br J Cancer 2000; 83, 421-425.

Bailey, D., & Baldwin, D. on behalf of the Head and Neck Tumour Panel (2001) - Second Head and Neck Audit Report – SWAHN II Audit SWAHN I Outcome at 2 years, South West Cancer Intelligence Service, September 2001.

Bailey, D., & Baldwin, D. on behalf of the Head and Neck Tumour Panel (2005) - Third Head and Neck Cancer Audit Report, South West Cancer Intelligence Service, May 2005.

National Standards for Head and Neck Cancer Services 2005
http://www.wales.nhs.uk/sites3/docmetadata.cfm?orgid=362&id=43257

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MEMBERSHIP

The following categories of subscribing membership are available. Please contact the Honorary Secretary if you need further information. An application form can be downloaded here. Current members should contact the Honorary Secretary if they wish to change their membership status.

* Full Members
  Clinicians who are involved in head and neck oncology and who are on the United Kingdom or Republic of Ireland specialist register for their parent specialty, or senior scientists or academic workers in the United Kingdom or Republic of Ireland who are involved in teaching or research in areas related to head and neck oncology. (Current subscription £50)

* Associate Members
  Trainees undertaking approved training programmes which entitle them to enrolment on the United Kingdom or Republic of Ireland specialist register for their parent specialty, or junior scientists and academic workers in the United Kingdom or Republic of Ireland who are involved in teaching or research in areas related to head and neck oncology. (Current subscription £25)

* Overseas Members
  Clinicians or scientific workers in the field of head and neck oncology who are residents of countries other than the United Kingdom or Republic of Ireland. (Current subscription £25)

* Affiliate Members
  Members of any relevant professional organisation approved by Council which has recognised involvement in head and neck oncology. Relevant professions will include nursing, dietetics, speech and language therapy, therapeutic radiography or physiotherapy. Applicants are asked to give the name of the organisation of which they are members when applying. (Current subscription £10)

In addition to subscribing members there are two categories of members who pay no fees:

* Honorary Members
  Elected by the Association because they have rendered distinguished service to head and neck oncology.

* Senior Members
  Former subscribing members of the Association of whatever category who have retired from active practice.

BAHNO is essentially an educational association and is not an accrediting body. The following extract from the Constitution is given for clarification.
'Membership of the Association, of whatever category, does not confer recognised accredited status as a specialist in head and neck oncology'

Further printed copies of this document are available for £15 to cover delivery costs by contacting the secretariat by e-mail at: secretariat@bahno.org.uk

The whole document can be downloaded free in PDF format at www.bahno.org.uk