# Quality of Oncology Information for New Patient Histories

**Descriptor:**

New patient histories (NPH) are dictated on first presentation of a patient into the oncology system. This is one of the key mechansims for the transfer of information to other oncologists, secondary and primary care. Their quality is therefore of key importance.

**Background:**

New patient histories (NPH) are dictated on first presentation of a patient into the oncology system. The information in these are usually the basis for communication with secondary care referrers and with primary care. The NPH is used by oncologists to make determinations on management plan. Their quality is therefore of key importance.

The communication of prognosis to cancer patients is a fundamental part of the provision of appropriate information regarding disease, treatment and outcomes. Studies show that patients rarely raise important questions during the clinical consultation, many assuming the doctor will have told them everything that is relevant [1,2]. Patients infrequently asked about prognosis and physicians rarely offered such information, assuming that when patients did not ask, they did not want to know. It is therefore possible, that the important discussion of prognosis is neither broached by the doctor or patient, despite there being evidence to suggest that prognostic information is desired by the majority of cancer patients [3,4]. The Macmillan Cancer Support, recommend the use of median survival times in determining the real progress in how long people are living after their cancer diagnosis [5].

## The Cycle

**The standard:**

Stage and performance status should be available in 80% of NPH. Treatment intent, drug allergies and management plan should be in all (100%).

**Target:**

Stage and performance status should be available in 80% of NPH. Treatment intent, drug allergies and management plan should be in all (100%).

## Assess local practice

**Indicators:**

• Recording of key pieces of information

• An audit proforma has been constructed (see attached) to give a global score of 100; dividing 10 points in each of the domains:

- Stage

- Performance status

- Drug history

- Past medical history

- Examination

- Social history

- Family history

- Management plan

- Treatment intent and GP letter

• Data on fields within these subgroups was also collected (eg TNM scoring, drug list and allergies)

**Data items to be collected:**

• T, N M, AJCC TSage

• Performance Status (preferably by WHO or KPS), "woolly PS" ( eg "looks in good state") might be allowable dependent on local preference

• Drug History- drug allergies, smoking history, alcohol history, drug list, drug doses

• Past medical history (recorded or not)

• Social History (recorded or not)

• Family History (recorded or not)

• Examination (recorded or not)

• Treatment Intent:

- Qualitative (whether patient in palliative or curative/ adjuvant setting)

- Quantitative (whether a quantitative prognosis discussion was offered (quantitative prognosis is defined in figures - median or absolute cure rates, 1 year overall survival) etc.)

• Management plan (recorded or not)

• Letter sent to referrer/ GP (recorded or not)

**Suggested number:**

Recommend at least 5 histories to be assessed for each individual doctor to allow individual feedback against the group/ peers performance.

**Suggestions for change if target not met:**

Individual feedback (feedback to individual on their individual scores i.e. Percentage PS recorded, percentage stage recorded against the overall group scores); allows clinicians to see how they are doing realitive to their peers.

**Resources:**

• The completion of the proforma is quite quick. We have had ward doctors and audit personnel doing as well as consultants. If non-consultant filling in forms it is best to run through what is meant by terms and to quality - assure approx. 10% of the completed proformas

• Takes 5-10 minutes to fill in each proforma

[**48\_RCR audit NPH Re audit (3) (2) (2).doc**](https://www.rcr.ac.uk/sites/default/files/audit_template/co/48_RCR%20audit%20NPH%20Re%20audit%20%283%29%20%282%29%20%282%29.doc)WORD - 254 KB

**References:**

1. Fallowfield L and Jenkins V (1999) Effective communication skills are the key to good cancer care. Eur J Can 35 (11): 1592–1597
2. Schapira L (2004) Shared uncertainty. J Support Oncol 2:14,18.
3. Lobb EA, Butow PN, Kenny DT, Tattersall MH (1999) Communicating prognosis in early breast cancer: do women understand the language used? Med J Australia; 171: 290–294.
4. Kaplowitz SA, Campo S, Chui WT (2002) Cancer patients’ desire for communication of prognosis information. Health Comm; 14: 221-241
5. Living after diagnosis: Median Cancer Survival Times: a research briefing paper by Macmillan Cancer Support. Accessed online at [http://www.macmillan.org.uk/Documents/AboutUs/Newsroom/LivingAfterCancerMedianCancerSurvivalTimes](http://www.macmillan.org.uk/Documents.AboutUs/Newsroom/LivingAfterCancerMedianCancerSurvivalTimes)  on 23rd March 2013

**Editor's comments:**

The attached document explains the audit and how it has been used in one centre to improve recording in the notes.

**Submitted by:**

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