

# **National Comparative Head and Neck Cancer Audit (DAHNO) CSV file upload specification, incorporating Phase II**

## Amendment History

Version	Date Issued	Brief Summary of Change	Owner's Name/Signature
1.0	27/04/2004	Final version	June Parry
1.1	26/05/2004	Updated with CSV File creation additions for consultation	June Parry
1.2		Corrections agreed with Steven Cooper	Beverley Meeson
1.3		Revisions to surgical procedures	Beverley Meeson
1.4		Style changes	Steven Cooper/BM
1.5		Correct UICC6 table	Toby Hewlett
1.6	12/07/2005	Minor revisions	Annamarie O'Connor
2.0	14/02/2008	Updated to incorporate Phase II, web-DAHNO application	Nancy Horseman
2.1	13/06/2008	Minor Revisions	Julie Michalowski
2.4	11/08/2008	Minor Revisions	Julie Michalowski
2.5	12/08/2008	Minor Revisions	Julie Michalowski
2.6	12/08/2008	Minor Revisions	Julie Michalowski
2.7	26/09/2008	Minor Revisions to surgery.csv, SurgicalVoiceRestoration.csv and Diagprocedure.csv	Arthur Yelland

Version	Date Issued	Brief Summary of Change	Owner's Name/Signature
2.8	07/11/2008	Update mandatory field column	Arthur Yelland
2.9	14/11/2008	Unspecified codes added in Care Plan & Diagnosis Summary	Julie Michalowski
2.10	NOT ISSUED		Julie Michalowski
2.11	NOT ISSUED		Julie Michalowski
2.12	21/07/2009	Revised mandatory fields Code Changes –Care Plan, Imaging, Diagnostic Procedure, Diagnostic Summary, Surgery Deleted fields – Diagnostic Summary	Julie Michalowski
2.13	10/08/2009	T&N permitted values warning in Diagnosis Summary and Surgery	Julie Michalowski
2.14	11/08/2009	Radiotherapy treatment site added to Brachytherapy	Julie Michalowski

Blue – Removed items

Red – Added / Modified items

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## **1. Introduction**

- 1.1. DAHNO, Data for Head and Neck Oncology is one of a number of projects and services supported by The Information Centre health and social care's National Clinical Audit Support Programme.
- 1.2. The DAHNO application is designed to facilitate collection of data for the purposes of auditing the provision of care to patients with head and neck cancers within the NHS.

## **2. DAHNO Dataset**

- 2.1. Clinical audit has always been an integral part of healthcare delivery within the NHS, as medical staff and clinicians continually review practice and delivery. As new and innovative models of care emerge from today's rapidly changing NHS

environment, health professionals have an even greater responsibility to carry out audit of their clinical practice.

- 2.2. Data collected is based on the national cancer dataset, specifically the subset for head and neck cancer, but includes additional items identified as relevant to audit priorities for Phase II of the National Head and Neck Cancer Audit by the Head and Neck Cancer Reference Group.
- 2.3. Detailed information on data definitions, derivation of data items, and the range of allowable values can be found in the DAHNO dataset v2.2, available on [www.ic.nhs.uk/canceraudits](http://www.ic.nhs.uk/canceraudits) following the link to Head & Neck Cancer Audit.

### **3. Uploading Files into the DAHNO Application**

#### **CREATING A CSV FILE**

- 3.11. To manually create a CSV file for importing, use either Notepad or Microsoft Excel. If you are using Microsoft Excel, set up a spreadsheet with a column for each data item. The first row in the spreadsheet can be a header row to help you identify the data in each column. When saving the new file, use SaveAs and choose CSV (Comma delimited)(\* .csv) as the option – see 3.15 below. Once the file is saved, open it in Notepad and check that it looks correct, eg, spaces are separated with commas:  
4567890123,RVH21,RVH21,3,6,7,,8,9  
4567890124,RVH21,RVH21,4,5,6,7,8,9
- 3.12. This must adhere to the DAHNO Dataset in terms of type and size of data field e.g. Patient Date of Birth. Date (dd/mm/yyyy).
- 3.13. If you have created a header row you must enter the data for the first patient in the row immediately below this one.
- 3.14. Use the format functionality within Excel to ensure all dates entered remain in the correct format i.e. cell format.
  - ◆ Select the column containing the data fields
  - ◆ Click Format

- ◆ Select Cells
- ◆ The Format Cell dialog box will open
- ◆ Select the Number tab and then from the Category List, select Date
- ◆ Choose the entry within the Type list which shows DD/MM/YYYY
- ◆ Click OK

NOTE: Incorrect date formats in externally created files may show correctly in Excel. Always examine files from external systems in Notepad.

3.15. Once you have complete rows for each patient you must save the spreadsheet as a text file:

- ◆ Click *File*, then *Save As*
- ◆ Under 'Save as Type', select CSV (Comma Delimited)
- ◆ Choose a file name
- ◆ Select the option to save only the active sheet and select Yes to keep the format
- ◆ Close Excel
- ◆ Your CSV File is now ready for upload

#### **4. Data Definitions**

4.1. Detailed information on data definitions, derivation of data items, and the range of allowable values can be found in the DAHNO dataset v2.2 available on [www.ic.nhs.uk/canceraudits](http://www.ic.nhs.uk/canceraudits)

# PATIENT

## PATIENT.CSV

CSV Field No	Dataset Ref	Field Name	Mandatory	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Numeric National 10 digit NHS number
2		Hospital identifier (Submitting organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s)
3	1.3	Hospital identifier (Contact organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient
4	1.2	Patient case record number		Any value / format	Text field – single value Local to each organisation
5	1.5	Surname	Yes	Any text	Patient's surname
6	1.6	Forename	Yes	Any text	Patient's forename
7	1.8	Patient post code		Up to 8 character post code	Patient's post code of usual address at the time of diagnosis
8	1.9	Patient sex	Yes	1 2 0 9	Text field – single value A coded item used to record sex, where: 1. Male 2. Female 0. Unknown 9. Not specified
9	1.10	Date of birth	Yes	DD/MM/YYYY	Patient's date
10	1.12	GP Practice Code		6 character national GP practice code	Practice with whom the patient is registered

Example. The following example shows two records, one with quotation marks and one without. (Note: A file must contain lines with quotation marks or lines without, but not both):

Either: "4000103903","RW821","RW346","CD2212","Smith","Thomas","GU289JW","1","18/03/1942","N8115"

Or: 4000103903,RW821,IAW, CD2402,Bell,Grace,2,15/04/1940,N8115

The following example shows data missing in the middle of a record:

"4000103903","RW821","IAW","CD2212","Smith","Thomas","","","18/03/1942","N8115"

The following example shows data missing at the end of a record:

"4000103903","RW821","IAW","CD2212","Smith","Thomas","","","18/03/1942",""

DAHNO Phase II CSV v2.14 (11/08/09)

# CARE SPELL

## CARESPELL.CSV

CSV Field No	Dataset Ref	Field Name	Mandatory	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Numeric National 10 digit NHS number
2		Hospital identifier (Submitting organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s)
3	1.3	Hospital identifier (Contact organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient
4	1.2	Patient case record number		Any value / format	Text field – single value Local to each organisation
5	4.1	Date of Diagnosis		DD/MM/YYYY	Date format including forward slash. Included for data integrity purposes, to ensure correct linking of files.
6	2.1	Source of Referral		01  02 03  04 05  06 07 08 10  92 93 99	Text field – single value A coded item used to record where the referral originates. Where: 01. Following an emergency admission (includes all acute admissions via A&E, Medical Admissions Unit, etc) 02. Following a domiciliary visit by the consultant 03. Referral from General Medical Practitioner (for out-patient or other non-emergency referrals) 04. Referral from an A&E department 05. Referral from a consultant, other than in an A&E department (will include referrals from Screening Services) 06. Self-referral (ie the patient was not seen previously by a GP) 07. Prosthetist 08. Other source of referral (will include referrals from Private Healthcare) 10. Following an A&E attendance (ie an out-patient clinic attendance after A&E visit) 92. General Dental Practitioner 93. Community Dental Service

## CARE SPELL

					99. Not known (default)
7	2.4	Referral priority		01 02	Text field – single value A coded item used to record referral priority. Where: 01. Urgent referral for suspected cancer from a General Medical Practitioner or General Dental Practitioner 02. Other referral source or urgency
8	2.5	Referral for cancer decision date	Yes	DD/MM/YYYY	Date format including forward slash
9	2.6	Date referral request received		DD/MM/YYYY	Date format including forward slash
10	2.9	Date first seen		DD/MM/YYYY	Date format including forward slash
11	HN.11	Date symptoms first noted		DD/MM/YYYY	Date format including forward slash

## CARE PLAN

### CAREPLAN.CSV

CSV Field No	Dataset Ref	Field Name	Mandatory	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Numeric National 10 digit NHS number
2		Hospital identifier (Submitting organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s)
3	1.3	Hospital identifier (Contact organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient
4	1.2	Patient case record number		Any value / format	Text field – single value Local to each organisation
5	4.1	Date of Diagnosis		DD/MM/YYYY	Date format including forward slash. Included for data integrity purposes, to ensure correct linking of files.
6	5.1	MDT discussion indicator	Yes	Y N	Text field – single value Indication of formal review by specialist team
7	5.2	MDT discussion date		DD/MM/YYYY	Date format including forward slash
8	5.3	Care Plan agreed date	Yes	DD/MM/YYYY	Date format including forward slash
9	5.5	Cancer Care Plan intent		C P S N 9	Text field – single value A coded item to record the intention of the treatment being planned, where: C. Curative P. Palliative anti-cancer S. Supportive treatment N. No specific anti-cancer treatment 9. Not known (default)

## CARE PLAN

10	Planned cancer treatment type 1	5.6 and 5.7		01 02 03 04 05 06 07 08 09 99	Text field – single value Coded items to identify treatment types, where: 01. Surgery 02. Teletherapy 03. Chemotherapy 04. Hormone Therapy 05. Specialist Palliative Care 06. Brachytherapy 07. <i>Biological</i> 08. Other 09. Active Monitoring 99. Not known (default)
11	Planned cancer treatment type 2	5.6 and 5.7		01 02 03 04 05 06 07 08 09 99	Text field – single value Coded items to identify treatment types, where: 01. Surgery 02. Teletherapy 03. Chemotherapy 04. Hormone Therapy 05. Specialist Palliative Care 06. Brachytherapy 07. Biological 08. Other 09. Active Monitoring 99. Not known (default)
12	Planned cancer treatment type 3	5.6 and 5.7		01 02 03 04 05 06 07 08 09 99	Text field – single value Coded items to identify treatment types, where: 01. Surgery 02. Teletherapy 03. Chemotherapy 04. Hormone Therapy 05. Specialist Palliative Care 06. Brachytherapy 07. <i>Biological</i> 08. Other 09. Active Monitoring 99. Not known (default)

## CARE PLAN

13	Planned cancer treatment type 4	5.6 and 5.7		01 02 03 04 05 06 07 08 09 99	Text field – single value Coded items to identify treatment types, where: 01. Surgery 02. Teletherapy 03. Chemotherapy 04. Hormone Therapy 05. Specialist Palliative Care 06. Brachytherapy 07. <i>Biological</i> 08. Other 09. Active Monitoring 99. Not known (default)
14	Comorbidity index	5.9		0 1 2 3	Text field – single value Based on the ACE 27 coding system which converts levels of decompensation from comorbidities into a numeric value, where: 0. No Co-morbidity 1. Mild Decomensation 2. Moderate Decomensation 3. Severe Decomensation
15	Performance status at present	5.10		0 1 2 3 4 5	Text field – single value Coding as WHO Handbook (plus code 5 added), where: 0. Able to carry out all normal activity without restriction 1. Restricted in physically strenuous activity but able to walk and do light work 2. Able to walk and capable of all self care but unable to carry out any work. 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 5. Not recorded
16	Primary care communication sent date	HN.20		DD/MM/YYYY	Date format including forward slash
17	Dental assessment date	HN.22		DD/MM/YYYY	Date format including forward slash
18	Speech and Language assessment date	HN.23		DD/MM/YYYY	Date format including forward slash
19	Clinical trial patient status	13.1			Text field – single value Coded item to record the status of the clinical trial entry for the patient, where:

## CARE PLAN

				EE ED 1	EE. patient eligible, consented to and entered trial ED. patient eligible, declined trial I. Ineligible for trial
20	Recurrence Indicator	5.4		N Y	Text field – single value N - No, this management plan relates to the original primary cancer Y- Yes, this management plan relates to a recurrence

## CARE PLAN

21	Primary diagnosis (primary site)	4.2	Yes		<p>Text field – single value The main cancer site for which the patient is receiving care. ICD-10 Coding, where:</p> <p><b>ORAL CAVITY</b></p> <p>C00.3 Lip, inner aspect, mucosa of upper C00.4 Lip, inner aspect, mucosa of lower C06.0 Cheek mucosa C06.1 Mouth, vestibule (buccal sulcus and labial) C06.2 Retromolar trigone C03.0 Gum, upper (alveolar ridge, mucosa, gingiva) C03.1 Gum, lower (alveolar ridge, mucosa, gingiva) C04.0 Mouth, anterior floor C04.1 Mouth, lateral floor C04.8 Mouth, floor, overlapping lesion C05.0 Palate, hard C02.0 Tongue, dorsal surface, anterior 2/3 C02.1 Tongue, lateral border, tip of tongue C02.2 Tongue, ventral, inferior surface C02.8 Tongue, overlapping lesion of anterior two-third C02.3 Anterior two-thirds of tongue, part unspecified C06.8 Overlapping lesion of other and unspecified parts of mouth <b>C02.4</b> Lingual tonsil (previously in oropharynx)</p> <p><b>OROPHARYNX</b></p> <p>C09.0 Tonsillar fossa C09.1 Tonsillar pillar, glossotonsillar sulcus C09.9 Tonsil, not otherwise specified C10.2 Lateral wall oropharynx C01 Base of tongue C10.0 Vallecula (Anterior surface epiglottis – see supraglottic larynx) C10.3 Posterior wall oropharynx C05.1 Palate, soft, inferior surface C05.2 Uvula <b>C02.4</b> Lingual tonsil (relocated to Oral Cavity) C05.8 Overlapping lesion palate C10.8 Overlapping lesion of oropharynx <b>C10.9</b> Oropharynx unspecified</p> <p><b>NASOPHARYNX</b></p> <p><b>NASOPHARYNX</b></p>
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## CARE PLAN

				<p>C11.0 C11.1 C11.2 C11.3 C11.8 C11.9</p> <p><b>HYPOPHARYNX</b> C12.x or C12.9 C13.0 C13.1 C13.2 C13.8 C13.0</p> <p><b>LARYNX</b></p> <p>C32.1 C10.1 C32.1A C32.1B C32.3A C32.1D C32.1E</p> <p>C32.0 C32.0B C32.0C C32.9 C32.0A</p> <p>C32.2 C32.3 C32.3B C32.3C</p>	<p>C11.0 C11.1 C11.2 C11.3 C11.8 C11.9</p> <p><b>HYPOPHARYNX</b> C12.x or C12.9 C13.0 C13.1 C13.2 C13.8 C13.9</p> <p><b>LARYNX</b></p> <p>Supraglottis – subsite OPTIONAL BAHNO SUPPLEMENTARY CODES C32.1 C10.1 C32.1A C32.1B C32.3A C32.1D C32.1E</p> <p>**Glottis – subsite OPTIONAL BAHNO SUPPLEMENTARY CODES C32.0 C32.0B C32.0C C32.9 C32.0A</p> <p>Subglottis C32.2 C32.3 C32.3B C32.3C</p>	<p>Nasopharynx, roof Nasopharynx, posterior wall Nasopharynx, lateral wall, fossa of Rosenmuller Nasopharynx, inferior, upper surface soft palate Nasopharynx, overlapping lesion Nasopharynx unspecified</p> <p>Pyriform sinus Postcricoid region Aryepiglottic fold, hypopharyngeal aspect Hypopharynx, posterior wall Hypopharynx, overlapping lesion Hypopharynx unspecified</p> <p>Supraglottis Anterior surface epiglottis Suprahyoid epiglottis (tip, laryngeal surface) Aryepiglottic fold, laryngeal aspect Arytenoid Infrahyoid epiglottis False cords</p> <p>Glottis Anterior commissure Posterior commissure Larynx, not otherwise specified Vocal cords, true</p> <p>Subglottis Subglottis Laryngeal cartilage Cricoid cartilage Thyroid cartilage</p>
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# CARE PLAN

				<b>MAJOR SALIVARY GLANDS</b> C07.x or C07.9 C08.0 C08.1	<b>MAJOR SALIVARY GLANDS (for minor refer to anatomic site found)</b> C07.x or C07.9 Parotid gland C08.0 Submandibular, submaxillary gland C08.1 Sublingual gland

## CARE PLAN

22	Pre-Treatment Tumour Site T category	6.1		<p><b>ORAL CAVITY</b></p> <p>T1 T2 T3 T4a T4b TX</p> <p><b>OROPHARYNX</b></p> <p>T1 T2 T3 T4a T4b TX</p> <p><b>NASOPHARYNX</b></p> <p>T1 T2 T2a T2b T3 T4</p> <p><b>HYPOPHARYNX</b></p> <p>T1 T2</p>	<p><b>ORAL CAVITY</b> (if 21 above contains any of C00.3, C00.4, C06.0, C06.1, C06.2, C03.0, C03.1, C04.0, C04.1, C04.8, C05.0, C02.0, C02.1, C02.2, C.02.8) T1. &lt;= 2 cm T2. &gt;2 to 4 cm T3. &gt; 4 cm T4a. Through cortical bone; deep/extrinsic muscle of tongue; maxillary sinus; skin T4b. Masticator space; pterygoid plates; skull base; encases internal carotid artery TX. Primary tumour cannot be assessed</p> <p><b>OROPHARYNX</b> (if 21 above contains any of C09.0, C09.1, C09.9, C10.2, C01, C10.0, C10.3, C05.1, C05.2) T1. &lt;= 2 cm T2. &gt;2 to 4 cm T3. &gt; 4 cm T4a. Invades larynx; deep/extrinsic muscle of tongue; medial/pterygoid; hard palate; mandible T4b. Invades lateral pterygoid muscle; pterygoid plates; lateral nasopharynx; skull base; encases carotid artery TX. Primary tumour cannot be assessed</p> <p><b>NASOPHARYNX</b> (If 21 above contains C11.0, C11.1, C11.2, C11.3, C11.8) T1. Confined to nasopharynx T2. Soft tissue T2a. Extends to Oropharynx; nasal cavity without parapharyngeal extension T2b. Tumour with parapharyngeal extension T3. Bony structures; paranasal sinuses T4. Invades intracranial; cranial nerves; infratemporal fossa; hypopharynx; orbit; masticator space</p> <p><b>HYPOPHARYNX</b> (If 21 above contains C12.x, C12.9, C13.0, C13.1, C13.2, C13.8) T1. &lt;= 2 cm and limited to one subsite T2. &gt;2 to 4 cm or more than one subsite T3. &gt; 4 cm or with hemilarynx fixation T4a. Invades thyroid cartilage; trachea; soft tissues of neck; deep/extrinsic muscle of</p>
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## CARE PLAN

				<p>T3 T4a T4b</p> <p><b>LARYNX</b></p> <p>T1 T2 T3 T4a T4b TX</p> <p><b>Glottis</b></p> <p>T1a T1b T2 T3 T4a T4b</p> <p><b>Subglottis</b></p> <p>T1 T2 T3 T4a T4b</p> <p><b>MAJOR SALIVARY</b></p>	<p>tongue; strap muscles thyroid; oesophagus T4b. Invades prevertebral fascia; encases carotid artery; mediastinal structures</p> <p><b>LARYNX</b> <b>Supraglottis</b> (if 21 above contains any of C32.1, C10.1, C32.1A, C32.1B, C32.3A, C32.1D, C32.1E) T1. One subsite; normal mobility T2. Mucosa &gt;1 adjacent subsite supraglottis/glottis/adjacent region outside supraglottis; without fixation T3. Cord fixation/invades postcricoid area; pre-epiglottic tissues; paraglottic space; thyroid cartilage erosion T4a. Invades through thyroid cartilage; trachea; soft tissues of neck: deep/extrinsic muscle of tongue; strap muscles; thyroid; oesophagus T4b. Invades prevertebral space; mediastinal structures; encases carotid artery TX. Primary tumour cannot be assessed</p> <p><b>Glottis</b> (if 21 above contains any of C32.0, C32.0B, C32.0C, C32.9)  T1a. Limited to vocal cord(s); normal mobility one cord T1b. Limited to vocal cord(s); normal mobility both cords T2. Supraglottis; subglottis; impaired cord mobility T3. Cord fixation; paraglottic space; thyroid cartilage erosion T4a. Invades through thyroid cartilage; trachea; soft tissues of neck: deep/extrinsic muscle of tongue; strap muscles; thyroid; oesophagus T4b. Invades prevertebral space; mediastinal structures; encases carotid artery</p> <p><b>Subglottis</b> (if 21 above contains any of C32.2, C32.3, C32.3B, C32.3C)  T1. Limited to subglottis T2. Extends to vocal cord(s) with normal/impaired mobility T3. Cord fixation T4a. Invades through cricoid/thyroid cartilage; trachea; deep/extrinsic muscle of tongue; strap muscles; thyroid; oesophagus T4b. Invades prevertebral space; mediastinal structures; encases carotid artery</p> <p><b>MAJOR SALIVARY GLANDS</b> (if 21 above contains any of C07.x, C07.9 C08.0, C08.1)</p>
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## CARE PLAN

				<b>GLANDS</b> T1 T2 T3 T4a T4b	T1. <=2 cm; without extraparenchymal extension T2. > 2 to 4cm; without extraparenchymal extension T3. >4 cm and/or extraparenchymal extension T4a. Invades skin; mandible; ear canal; facial nerve T4b. Invades skull; pterygoid plates; encases carotid artery
23	Pre-Treatment Staging certainty T category	6.2		C1 C2 C3 C4 C5	Text field – single value Coded item to record the validity of the “T” part of the ‘TNM’ classification C1. Evidence from standard diagnostic means C2. Evidence obtained from special diagnostic means C3. Evidence from surgical exploration, including biopsy and cytology C4. Evidence following definitive surgery and pathological examination of the resected specimen C5. Evidence from autopsy
24	Pre-Treatment Tumour site N category	6.3		<b>ORAL CAVITY</b> N0 N1 N2A N2B N2C N3 NX  <b>OROPHARYNX</b> N0 N1 N2A N2B N2C N3	<b>ORAL CAVITY</b> (if 21 above contains any of C00.3, C00.4, C06.0, C06.1, C06.2, C03.0, C03.1, C04.0, C04.1, C04.8, C05.0, C02.0, C02.1, C02.2, C.02.8) N0. No nodal involvement N1. Ipsilateral single <= 3cm N2A. Ipsilateral single node > 3 to 6 cm N2B. Ipsilateral multiple <= 6 cm N2C. Bilateral; contralateral <= 6cm N3. > 6 cm NX. Regional lymph nodes cannot be assessed  <b>OROPHARYNX</b> (if 21 above contains any of C09.0, C09.1, C09.9, C10.2, C01, C10.0, C10.3, C05.1, C05.2) N0. No nodal involvement N1. Ipsilateral single <= 3cm N2A. Ipsilateral single node > 3 to 6 cm N2B. Ipsilateral multiple <= 6 cm N2C. Bilateral; contralateral <= 6cm N3. > 6cm

## CARE PLAN

				<p>NX</p> <p><b>NASOPHARYNX</b></p> <p>N0 N1 N2 N3a N3b NX</p> <p><b>HYPOPHARYNX</b></p> <p>N0 N1 N2A N2B N2C N3 NX</p> <p><b>LARYNX</b></p> <p>N0 N1 N2A N2B N2C N3 NX</p> <p><b>MAJOR SALIVARY GLANDS</b></p>	<p>NX. Regional lymph nodes cannot be assessed</p> <p><b>NASOPHARYNX</b></p> <p>(If 21 above contains C11.0, C11.1, C11.2, C11.3, C11.8) N0. No nodal involvement N1. Unilateral node(s) &lt; 6cm above supraclavicular fossa N2. Bilateral node(s) &lt; 6cm above supraclavicular fossa N3a. &gt; 6cm N3b. In supraclavicular fossa NX. Regional lymph nodes cannot be assessed</p> <p><b>HYPOPHARYNX</b></p> <p>(If 21 above contains C12.x, C12.9, C13.0, C13.1, C13.2, C13.8) N0. No nodal involvement N1. Ipsilateral single &lt;= 3cm N2A. Ipsilateral single node &gt; 3 to 6 cm N2B. Ipsilateral multiple &lt;= 6 cm N2C. Bilateral; contralateral &lt;= 6cm N3. &gt; 6cm NX. Regional lymph nodes cannot be assessed</p> <p><b>LARYNX</b></p> <p>(if 21 above contains any of C32.1, C10.1, C32.1A, C32.1B, C32.3A, C32.1D, C32.1E, C32.0, C32.0B, C32.0C, C32.9, C32.2, C32.3, C32.3B, C32.3C) N0. No nodal involvement N1. Ipsilateral single &lt;= 3cm N2A. Ipsilateral single node &gt; 3 to 6 cm N2B. Ipsilateral multiple &lt;= 6cm N2C. Bilateral; contralateral &lt;= 6cm N3. &gt; 6 cm NX. Regional lymph nodes cannot be assessed</p> <p><b>MAJOR SALIVARY GLANDS</b></p> <p>(if 21 above contains any of C07.x, C07.9, C08.0, C08.1)</p>
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## CARE PLAN

				N0 N1 N2A N2B N2C N3 NX	N0. No nodal involvement N1. Ipsilateral single <= 3cm N2A. Ipsilateral single node > 3 to 6 cm N2B. Ipsilateral multiple <= 6cm N2C. Bilateral; contralateral <= 6cm N3. > 6 cm NX. Regional lymph nodes cannot be assessed
25	Pre-Treatment Staging certainty N category	6.4		C1 C2 C3 C4 C5	Text field – single value Coded item to record the validity of the “N” part of the ‘TNM’ classification C1. Evidence from standard diagnostic means C2. Evidence obtained from special diagnostic means C3. Evidence from surgical exploration, including biopsy and cytology C4. Evidence following definitive surgery and pathological examination of the resected specimen C5. Evidence from autopsy
26	Pre-Treatment Tumour site M category	6.5		M0 M1 MX	Text field – single value. The ‘M’ part of the TNM classification UICC Coding (6 <sup>th</sup> Edition)
27	Pre-Treatment Staging certainty M category	6.6		C1 C2 C3 C4 C5	Text field – single value Coded item to record the validity of the “M” part of the ‘TNM’ classification C1. Evidence from standard diagnostic means C2. Evidence obtained from special diagnostic means C3. Evidence from surgical exploration, including biopsy and cytology C4. Evidence following definitive surgery and pathological examination of the resected specimen C5. Evidence from autopsy
28	Pre-Treatment Overall Stage pre-treatment	6.7			(Leave blank – derived from DAHNO system)
29	Pre-Treatment Staging certainty TNM category	6.8		C1 C2 C3 C4 C5	Text field – single value Coded item to record the validity of the “TNM” part of the ‘TNM’ classification C1. Evidence from standard diagnostic means C2. Evidence obtained from special diagnostic means C3. Evidence from surgical exploration, including biopsy and cytology C4. Evidence following definitive surgery and pathological examination of the resected specimen C5. Evidence from autopsy

### CARE PLAN

30	Professionals present at breaking of bad news	ClinNS 6		C D G M N O U	Text field – multi-value Coded item to record the Professionals Present at breaking of bad news  C. Clinical nurse specialist or designate D. Designated head neck surgeon/oncologist or designate G. General practitioner M. Non designated doctor N. Non designated nurse O. Other U. Unknown
31	Date patient advised of cancer diagnosis	ClinNS5		DD/MM/YYYY	Date format including forward slash

## IMAGING

### IMAGING.CSV

CSV Field No	Dataset Ref	Field Name	Mandatory	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Numeric National 10 digit NHS number
2		Hospital identifier (Submitting organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s)
3	1.3	Hospital identifier (Contact organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient
4	1.2	Patient case record number		Any value / format	Text field – single value Local to each organisation
5	4.1	Date of Diagnosis	Yes	DD/MM/YYYY	Date format including forward slash. Included for data integrity purposes, to ensure correct linking of files.
6	3.2	Clinical intervention date (cancer imaging)	Yes	DD/MM/YYYY	Date format including forward slash
7	3.3	Cancer imaging modality		1A 1B 1C 1D 1E 2A 2B 3A 3B 4 4A 5 6 6A 6B 8 8B 9 99	Text field – single value Coded item used to identify the type of imaging / technique used to produce the image, where: 1A. Chest X-ray 1B Sinus X-Ray 1C. Mastoid views 1D. Orthopantomogram (OPG) 1E. Skull base views 2A. CT Scan with contrast 2B. CT scan without contrast 3A. MRI scan with contrast 3B. MRI scan without contrast 4. PET scan 4A. PET-CT 5. Ultrasound 6. Nuclear Medicine imaging 6A. Bone scan 6B. Other isotope scan 8. Barium 8B. Barium swallow 9. Lymphoscintigraphy 99. Other

## IMAGING

8	3.4	Anatomical examination site		<p>Z01.1 Z01.9 Z13.1 Z22.6 Z24.1 Z24.2 Z25 Z25.1 Z25.5 Z25.6 Z25.7 Z25.9 Z26 Z26.1 Z26.2 Z26.3 Z30.1 Z52.8 Z61.1 Z63.8 Z65 Z92.1 Z92.3 Z92.4 Z92.6</p> <p>Multi-value, separated by a semi-colon;</p>	<p>OPCS 'Z' Coding. Z01.1 – Tissue of frontal lobe of brain Z01.9 – Brain (Tissue of brain nec) Z13.1 – Thyroid gland Z22.6 – Nasopharynx Z24.1 – Pharynx (excludes nasopharynx) Z24.2 – Larynx Z25 – Mouth Z25.1 – Lip Z25.5 – Tongue Z25.6 – Palate Z25.7 – Tonsil Z25.9 – Mouth nec Z26 Salivary apparatus Z26.1 – Parotid gland Z26.2 – Submandibular gland Z26.3 – Sublingual gland Z30.1 – Liver Z52.8 – Thorax (Specified chest wall nec) Z61.1 – Cervical lymph gland Z63.8 – Skull base (Specified bone of cranium nec) Z65 – Jaw Z92.1 – Head Z92.3 – Neck Z92.4 – Chest Z92.6 – Upper abdomen (Abdomen nec)</p>
9	HN.21	Image request date		DD/MM/YYYY	Date format including forward slash
10	HN.24	Date of image report		DD/MM/YYYY	Date format including forward slash

# DIAGPROCEDURE

## DIAGPROCEDURE.CSV

CSV Field No	Dataset Ref	Field Name	Mandatory	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Numeric National 10 digit NHS number
2		Hospital identifier (Submitting organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s)
3	1.3	Hospital identifier (Contact organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient
4	1.2	Patient case record number		Any value / format	Text field – single value Local to each organisation
5	4.1	Date of Diagnosis	Yes	DD/MM/YYYY	Date format including forward slash. Included for data integrity purposes, to ensure correct linking of files.
6	7.9	Diagnostic Procedure Date	Yes	DD/MM/YYYY	Date format including forward slash
7	7.10	Diagnostic Procedure	Yes	Multi-values allowed: Separate using semi-colon (D01;D02)	Text field – multi-value
				D01	D01. EUA and biopsy mouth _____ F42.1
				D02	D02. EUA and biopsy tongue _____ F24.1
				D03	D03. EUA and biopsy palate _____ F32.1
				D04	D04. Biopsy mouth _____ F42.1
				D05	D05. Biopsy tongue _____ F24.1
				D06	D06. Biopsy palate _____ F32.1
				D07	D07. Direct laryngoscopy and biopsy _____ E36.1
				D08	D08. Microlaryngoscopy and biopsy _____ E36.1
				D09	D09. Pharyngoscopy and biopsy _____ E25.1
				D10	D10. Oesophagoscopy and biopsy (rigid) _____ G19.1
				D11	D11. Oesophagoscopy and biopsy (flexible) _____ G16.1
				D12	D12. Tracheoscopy _____ E51.9 + Z24.3 (rigid)
				D13	D13. Bronchoscopy _____ E49.9 (flexi)
				D15	D15. Bronchoscopy _____ E51.9 (rigid) + Z24.5
				D17	D17. Fine needle aspiration cytology cervical node _____ T86.1 + Y22.2
				D22	D22. EUA and biopsy nasopharynx (mirror) - OPEN _____ E27.1
				D26	D26. EUA and biopsy oropharynx- OPEN _____ E27.1
				D30	D30. Pharyngoscopy _____ E25.1
				D31	D31. Oesophagoscopy _____ G16.1 (flexi) G19.1

## DIAGPROCEDURE

					(rigid)
			D35	D35. Bronchoscopy - RIGID_____	E51.9 (rigid) + Z24.5
			D45	D45. FNA Cytology parotid_____	F58.1 + Y22.2
			D47	D47. Incisional biopsy cervical lymph node _____	T87.2
			D51	D51. <b>Tracheostomy</b> (RIGID)_____	E42.1
			D52	D52. Direct Laryngoscopy_____	E36.1
			D53	D53. EUA & Biopsy nasopharynx (mirror)_____	E10.1 (nose) E25.1 (endoscopically)
					<u>E27.1 (open)</u>
			D54	D54. EUA and biopsy nasopharynx (telescope) – ENDOSCOPICALLY	E25.1
			D55	D55. EUA & Biopsy nasopharynx (telescope) open_____	E27.1 (open)
			D56	D56. EUA & biopsy oropharynx – endoscopically_____	E25.1
			D57	D57. EUA & biopsy nasopharynx – (mirror) endoscopically	E25.1
			D58	D58. EUA nasopharynx (mirror) open_____	E27.1
			D59	D59. EUA nasopharynx (telescope) endoscopically_____	E25.1
			D60	D60. EUA nasopharynx (telescope) open_____	E27.1
			D61	D61. EUA oropharynx_____	E27.1 (open) E25.1 (endoscopically)
			D63	D63. FNA of sublingual gland_____	F46.3
			D64	D64. FNA of submandibular gland_____	F46.2
			D65	D65. Incisional biopsy lesion parotid_____	F48.1 + Z26.1
			D66	D66. Incisional biopsy sublingual gland_____	F46.3
			D67	D67. Incisional biopsy submandibular gland_____	F46.2
			D68	D68. Microlaryngoscopy_____	E36.1
					<b>Where it is not possible to distinguish between different procedures (D codes) with the same OPCS code use the following D codes as follows:</b>
			D90	D90 Pharyngeal Endoscopy – E25.1	
			D91	D91 Biopsy Mouth unspecified – F42.1	
			D92	D92 Biopsy Tongue unspecified – F24.1	
			D93	D93 Biopsy Palate unspecified – F32.1	
			D94	D94 Laryngoscopy unspecified – E36.1	
			D95	D95 Oesophagoscopy (rigid) unspecified – G19.1	
			D96	D96 Sampling Submandibular gland – F46.2	
			D97	D97 Nasopharyngeal endoscopy – E27.1	

## DIAGPROCEDURE

				D98 D99	D98 Oesophagoscopy unspecified – G16.1 D99 Sampling Sublingual Gland – F46.3
8	7.4	Cancer treatment intent		C D S P A N 9	Text field – single value Coded item to record the intention of the treatment, where: C. Curative D. Diagnostic S. Staging P. Palliative A. Adjuvant N. Neoadjuvant 9. Not known (default)

## DIAG PATHOLOGY

### DIAGPATHOLOGY.CSV

CSV Field No	Dataset Ref	Field Name	Mandatory?	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Numeric National 10 digit NHS number
2		Hospital identifier (Submitting organisation) see note 8.3 above	Yes	Either 5 characters or 3 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s) (Note: the 3 character code is the code assigned by the DAHNO application <b>not</b> the 3 character national standard Trust code. This is included in the individual IDs, eg. Beverley Meeson/IAW/ccad. If in doubt contact the DAHNO helpdesk)
3	1.3	Hospital identifier (Contact organisation) see note 8.3 above	Yes	Either 5 characters or 3 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient (Note: the 3 character code is the code assigned by the DAHNO application <b>not</b> the 3 character national standard Trust code. This is included in the individual IDs, eg. Beverley Meeson/IAW/ccad. If in doubt contact the DAHNO helpdesk)
4	1.2	Patient case record number		Any value / format	Text field – single value Local to each organisation
5	4.1	Date of Diagnosis	Yes	DD/MM/YYYY	Date format including forward slash. Included for data integrity purposes, to ensure correct linking of files.
6	8.1	Pathology specimen type		CY BX EX 9	Type of specimen, where: CY. Cytology sample BX. Biopsy sample EX. Excision sample 9. Uncertain/other
7	8.3	Date of Pathology Report (Investigation Result Date)	Yes	DD/MM/YYYY	Date format including forward slash
8	8.10	Histology		<b>Squamous carcinoma and variants</b>  M8070/3 M8071/3 M8072/3 M8074/3 M8075/3 M8560/3	Text field – single value, where:  <b>Squamous carcinoma and variants</b> M8070/3 Squamous carcinoma (Not Otherwise Specified) M8071/3 Keratinising squamous carcinoma M8072/3 Non-keratinising squamous carcinoma M8074/3 Spindle cell squamous carcinoma M8075/3 Adenoid squamous carcinoma M8560/3 Adenosquamous carcinoma

## DIAG PATHOLOGY

				<p>M8051/3</p> <p><b>Salivary malignancies</b></p> <p>M8550/3</p> <p>M8430/3</p> <p>M8200/3</p> <p>M8525/3</p> <p>M8562/3</p> <p>M8147/3</p> <p>M8480/3</p> <p>M8500/3</p> <p>M8140/3</p> <p>M8941/3</p> <p>M8070/3</p> <p>M8041/3</p> <p>M8020/3</p>	<p>M8051/3 Verrucous carcinoma (Note M-8070/6, Squamous carcinoma, metastatic, not otherwise specified removed)</p> <p><b>Salivary malignancies</b></p> <p>M8550/3 Acinic cell carcinoma</p> <p>M8430/3 Mucoepidermoid carcinoma</p> <p>M8200/3 Adenoid cystic carcinoma</p> <p>M8525/3 Polymorphous low grade adenocarcinoma (terminal duct adenocarcinoma)</p> <p>M8562/3 Epithelial-myoepithelial carcinoma</p> <p>M8147/3 Basal cell adenocarcinoma</p> <p>M8480/3 Mucinous adenocarcinoma</p> <p>M8500/3 Salivary duct carcinoma</p> <p>M8140/3 Adenocarcinoma</p> <p>M8941/3 Carcinoma in pleomorphic adenoma (malignant mixed tumour)</p> <p>M8070/3 Squamous carcinoma (Not Otherwise Specified)</p> <p>M8041/3 Small cell carcinoma</p> <p>M8020/3 Undifferentiated carcinoma</p>
9	8.13	Exision margin		<p>A</p> <p>B</p> <p>C</p> <p>D</p> <p>U</p> <p>8</p>	<p>Text field – single value</p> <p>Coded item to record whether excision margins were free from tumour, where:</p> <p>A. Margin involved</p> <p>B. &lt; 1mm clear</p> <p>C. 1–5 mm clear</p> <p>D. &gt; 5 mm clear</p> <p>U. Uncertain</p> <p>8. Not applicable (default)</p>
10	8.22	Specimen nature		<p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p> <p>9</p>	<p>Text field – single value</p> <p>Coded item recording nature of the specimen recorded, where:</p> <p>1. Primary tumour</p> <p>2. Re–excision of primary tumour</p> <p>3. Recurrence</p> <p>4. Nodes</p> <p>5. Metastatic site other than nodes</p> <p>9. Not known</p>

## DIAGNOSIS SUMMARY

### DIAGNOSIS.CSV

CSV Field No	Dataset Ref	Field Name	Mandatory	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Numeric National 10 digit NHS number
2		Hospital identifier (Submitting organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s)
3	1.3	Hospital identifier (Contact organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient
4	1.2	Patient case record number		Any value / format	Text field – single value Local to each organisation
5	4.1	Date of Diagnosis	Yes	DD/MM/YYYY	Date format including forward slash. Included for data integrity purposes, to ensure correct linking of files.
6	4.2	Primary diagnosis (primary site)	Yes	<b>ORAL CAVITY</b> C00.3 C00.4 C06.0 C06.1 C06.2 C03.0 C03.1 C04.0 C04.1 C04.8 C05.0 C02.0 C02.1 C02.2 C.02.8 C02.3 C06.8 <b>C02.4</b>	Text field – single value The main cancer site for which the patient is receiving care. ICD-10 Coding, where:  <b>ORAL CAVITY</b> C00.3 Lip, inner aspect, mucosa of upper C00.4 Lip, inner aspect, mucosa of lower C06.0 Cheek mucosa C06.1 Mouth, vestibule (buccal sulcus and labial) C06.2 Retromolar trigone C03.0 Gum, upper (alveolar ridge, mucosa, gingiva) C03.1 Gum, lower (alveolar ridge, mucosa, gingiva) C04.0 Mouth, anterior floor C04.1 Mouth, lateral floor C04.8 Mouth, floor, overlapping lesion C05.0 Palate, hard C02.0 Tongue, dorsal surface, anterior 2/3 C02.1 Tongue, lateral border, tip of tongue C02.2 Tongue, ventral, inferior surface C02.8 Tongue, overlapping lesion of anterior two-third C02.3 Anterior two-thirds of tongue, part unspecified C06.8 Overlapping lesion of other and unspecified parts of mouth <b>C02.4 Lingual tonsil (previously in oropharynx)</b>

## DIAGNOSIS SUMMARY

				<p><b>OROPHARYNX</b>  C09.0  C09.1  C09.9  C10.2  C01  C10.0  C10.3  C05.1  C05.2  C02.4  C05.8  C10.8  C10.9</p> <p><b>NASOPHARYNX</b>  C11.0  C11.1  C11.2  C11.3  C11.8  C11.9</p> <p><b>HYPOPHARYNX</b>  C12.x or C12.9  C13.0  C13.1  C13.2  C13.8  C13.9</p> <p><b>LARYNX</b>   C32.1  C10.1  C32.1A</p>	<p><b>OROPHARYNX</b>  C09.0 Tonsillar fossa  C09.1 Tonsillar pillar, glossotonsillar sulcus  C09.9 Tonsil, not otherwise specified  C10.2 Lateral wall oropharynx  C01 Base of tongue  C10.0 Vallecula (Anterior surface epiglottis – see supraglottic larynx)  C10.3 Posterior wall oropharynx  C05.1 Palate, soft, inferior surface  C05.2 Uvula  C02.4 Lingual tonsil (relocated to Oral cavity)  C05.8 Overlapping lesion palate  C10.8 Overlapping lesion of oropharynx  C10.9 Oropharynx unspecified</p> <p><b>NASOPHARYNX</b>  C11.0 Nasopharynx, roof  C11.1 Nasopharynx, posterior wall  C11.2 Nasopharynx, lateral wall, fossa of Rosenmuller  C11.3 Nasopharynx, inferior, upper surface soft palate  C11.8 Nasopharynx, overlapping lesion  C11.9 Nasopharynx unspecified</p> <p><b>HYPOPHARYNX</b>  C12.x or C12.9 Pyriform sinus  C13.0 Postcricoid region  C13.1 Aryepiglottic fold, hypopharyngeal aspect  C13.2 Hypopharynx, posterior wall  C13.8 Hypopharynx, overlapping lesion  C13.9 Hypopharynx unspecified</p> <p><b>LARYNX</b>   Supraglottis – subsite OPTIONAL BAHNO SUPPLEMENTARY CODES  C32.1 Supraglottis  C10.1 Anterior surface epiglottis  C32.1A Suprahyoid epiglottis (tip, laryngeal surface)</p>
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## DIAGNOSIS SUMMARY

				<p>C32.1B C32.3A C32.1D C32.1E</p> <p>C32.0 C32.0B C32.0C C32.9</p> <p>C32.2 C32.3</p> <p>C32.3B C32.3C C32.0A</p> <p><b>MAJOR SALIVARY GLANDS</b> C07.x or C07.9 C08.0 C08.1</p>	<p>C32.1B Aryepiglottic fold, laryngeal aspect C32.3A Arytenoid C32.1D Infrahyoid epiglottis C32.1E False cords</p> <p><b>**Glottis – subsite OPTIONAL BAHNO SUPPLEMENTARY CODES</b></p> <p>C32.0 Glottis C32.0B Anterior commissure C32.0C Posterior commissure C32.9 Larynx, not otherwise specified</p> <p>Subglottis C32.2 Subglottis C32.3 Laryngeal cartilage</p> <p><b>**Laryngeal cartilage OPTIONAL BAHNO SUPPLEMENTARY CODES</b></p> <p>C32.3B Cricoid cartilage C32.3C Thyroid cartilage C32.0A <b>Vocal cords</b></p> <p><b>MAJOR SALIVARY GLANDS (for minor refer to anatomic site found)</b> C07.x or C07.9 Parotid gland C08.0 Submandibular, submaxillary gland C08.1 Sublingual gland</p>
7	4.3	Tumour laterality		<p>L R M B 8 9</p>	<p>Text field – single value Coded item to record laterality of the primary tumour, where: L. Left R. Right M. Midline B. Bilateral 8. Not applicable 9. Not known</p>
8	4.4	Basis of diagnosis			<p>Text field – single value Coded item to record the eligibility of the tumour for registration.</p> <p><b>Non-microscopic</b></p>

## DIAGNOSIS SUMMARY

			0 1 2 4 5 6 7 9	<p>0. Death Certificate (The only information available is from a death certificate)</p> <p>1. Clinical (Diagnosis made before death but without the benefit of any of the following (2–7))</p> <p>2. Clinical Investigation (Includes all diagnostic techniques (e.g. X-rays, endoscopy, imaging, ultrasound, exploratory surgery and autopsy) without a tissue diagnosis)</p> <p>4. Specific Tumour Markers (Includes biochemical and/or immunological markers which are specific for a tumour site)</p> <p><b>Microscopic</b></p> <p>5. Cytology (Examination of cells whether from a primary or secondary site, including fluids aspirated using endoscopes or needles. Also including microscopic examination of peripheral blood films and trephine bone marrow aspirates).</p> <p>6. Histology of a metastasis (Histological examination of tissues from a metastasis, including autopsy specimens)</p> <p>7. Histology of a primary tumour (Histological examination of tissue from the primary tumour, however obtained, including all cutting and bone marrow biopsies. Also includes autopsy specimens of a primary tumour)</p> <p>9. Not known (No information on how the diagnosis has been made (e.g. PAS or HISS record only)) (Default)</p>
9	4.5	Histology	<p><b>Squamous carcinoma and variants</b></p> <p>M8070/3 M8071/3 M8072/3 M8074/3 M8075/3 M8560/3 M8051/3</p> <p><b>Salivary malignancies</b></p> <p>M8550/3 M8430/3 M8200/3 M8525/3</p> <p>M8562/3 M8147/3</p>	<p>Text field – single value, where:</p> <p><b>Squamous carcinoma and variants</b></p> <p>M8070/3 Squamous carcinoma (Not Otherwise Specified)</p> <p>M8071/3 Keratinising squamous carcinoma</p> <p>M8072/3 Non-keratinising squamous carcinoma</p> <p>M8074/3 Spindle cell squamous carcinoma</p> <p>M8075/3 Adenoid squamous carcinoma</p> <p>M8560/3 Adenosquamous carcinoma</p> <p>M8051/3 Verrucous carcinoma</p> <p>(Note M-8070/6, Squamous carcinoma, metastatic, not otherwise specified removed)</p> <p><b>Salivary malignancies</b></p> <p>M8550/3 Acinic cell carcinoma</p> <p>M8430/3 Mucoepidermoid carcinoma</p> <p>M8200/3 Adenoid cystic carcinoma</p> <p>M8525/3 Polymorphous low grade adenocarcinoma (terminal duct adenocarcinoma)</p> <p>M8562/3 Epithelial-myoepithelial carcinoma</p> <p>M8147/3 Basal cell adenocarcinoma</p>

## DIAGNOSIS SUMMARY

				M8480/3 M8500/3 M8140/3 M8941/3 M8070/3 M8041/3 M8020/3	M480/3 Mucinous adenocarcinoma M8500/3 Salivary duct carcinoma M8140/3 Adenocarcinoma M8941/3 Carcinoma in pleomorphic adenoma (malignant mixed tumour) M8070/3 Squamous carcinoma (Not Otherwise Specified) M8041/3 Small cell carcinoma M8020/3 Undifferentiated carcinoma
10	6.11	Final Integrated Tumour site T category		See Care Plan, Appendix B of dataset or UICC 6 <sup>th</sup> Edition	Text field – single value UICC Coding (6 <sup>th</sup> Edition) <i>A full description of the UICC coding (6<sup>th</sup> Edition) can be found in Appendix B of the DAHNO Data Manualv2.2</i>
11		Final Integrated Staging certainty T category  (leave a blank to denote removal)		C1 C2 C3 C4  C5	Text field – single value Coded item to record the validity of the “T” part of the ‘TNM’ classification C1. Evidence from standard diagnostic means C2. Evidence obtained from special diagnostic means C3. Evidence from surgical exploration, including biopsy and cytology C4. Evidence following definitive surgery and pathological examination of the resected specimen C5. Evidence from autopsy
12	6.12	Final Integrated Tumour site N category		See Care Plan, Appendix B of dataset or UICC 6 <sup>th</sup> Edition	Text field – single value The ‘N’ part of the TNM classification UICC Coding (6 <sup>th</sup> Edition)
13		Final Integrated Staging certainty N category  (leave a blank to denote removal)		C1 C2 C3 C4  C5	Text field – single value Coded item to record the validity of the “N” part of the ‘TNM’ classification C1. Evidence from standard diagnostic means C2. Evidence obtained from special diagnostic means C3. Evidence from surgical exploration, including biopsy and cytology C4. Evidence following definitive surgery and pathological examination of the resected specimen C5. Evidence from autopsy
14	6.13	Final Integrated Tumour site M category		M0 M1 MX	Text field – single value. The ‘M’ part of the TNM classification UICC Coding (6 <sup>th</sup> Edition)
15		Final Integrated Staging certainty M category  (leave a blank to denote removal)		C1 C2	Text field – single value Coded item to record the validity of the “M” part of the ‘TNM’ classification C1. Evidence from standard diagnostic means C2. Evidence obtained from special diagnostic means

## DIAGNOSIS SUMMARY

		removal)		C3 C4  C5	C3. Evidence from surgical exploration, including biopsy and cytology C4. Evidence following definitive surgery and pathological examination of the resected specimen C5. Evidence from autopsy
16	6.10	Final Integrated Overall Stage pre-treatment			Derived value
17		Final Integrated Staging certainty TNM category  (leave a blank to denote removal)		C1 C2 C3 C4  C5	Text field – single value Coded item to record the validity of the “TNM” part of the ‘TNM’ classification C1. Evidence from standard diagnostic means C2. Evidence obtained from special diagnostic means C3. Evidence from surgical exploration, including biopsy and cytology C4. Evidence following definitive surgery and pathological examination of the resected specimen C5. Evidence from autopsy
18	8.3	Date Pathology Report		DD/MM/YYYY	

## SURGERY (includes resective pathology)

### SURGERY.CSV

CSV Field No	Dataset Ref	Field Name	Mandatory	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Numeric National 10 digit NHS number
2		Hospital identifier (Submitting organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s)
3	1.3	Hospital identifier (Contact organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient
4	1.2	Patient case record number		Any value / format	Text field – single value Local to each organisation
5	4.1	Date of Diagnosis	Yes	DD/MM/YYYY	Date format including forward slash. Included for data integrity purposes, to ensure correct linking of files.
6	5.3	Care Plan agreed date	Yes	DD/MM/YYYY	Date format including forward slash
7	7.4	Cancer treatment intent		D S C P 9	Text field – single value Coded item to record the purpose of the surgery, where: D. Diagnostic S. Staging C. Curative P. Palliative 9. Not known (default)
8	7.5	Date of decision to treat [Date of decision to operate]		DD/MM/YYYY	Date format including forward slash
9	7.9	<b>Procedure Date</b>	<b>Yes</b>	DD/MM/YYYY	Date format including forward slash
10	7.10	Primary procedure code (Main Surgical Procedure)		LARYNX E34.1 E34.2 E29.3 E29.2 E30.1 E29.5 E29.1	Text field – single value Coded item to record the main surgical procedure. Codes used are OCPC (as shown below), where:  <b>OPS LARYNX</b> 0101. microlaryngoscopy – laser removal lesion      E34.1 0102. microlaryngoscopy – cold removal lesion      E34.2 0103. vertical hemilaryngectomy      E29.3 0104. supraglottic laryngectomy      E29.2 0105. laryngofissure      E30.1 0106. laryngofissure and cordectomy      E29.5 0107. total laryngectomy      E29.1

## SURGERY (includes resective pathology)

			<p>E43.8 E42.1 E42.3 E42.4 E23.8</p> <p><b>PHARYNX</b> E23.1 E23.8 E19.2 E19.1;E29.1;E21.4 E19.1;E29.1'G03.2 E19.1;E29.1;E21.4;S17.1;Y61.2 E19.1;E29.1;G02.1 E23.8 F23.1 F34.9 E24.1</p> <p><b>NECK DISSESECTION</b></p> <p>T85.1 T85.1A T85.1AI T85.1AII T85.1AIII</p> <p>T85.1B T85.1BI T85.1BII T85.1BIII T85.1BIV T85.1BV T85.1BVI T85.1BVII</p>	<p>0108. te puncture E43.8 0109. tracheostomy, permanent E42.1 0110. tracheostomy, temporary E42.3 0111. Revision tracheal stoma E42.4 0202. cricopharyngeal myotomy E23.8</p> <p><b>OPS PHARYNX</b> 0201. pharyngotomy (open excision lesion) E23.1 0202. cricopharyngeal myotomy E23.8 0203. pharyngectomy, partial E19.2 0204. laryngo-pharyngectomy-Primary closure E19.1;E29.1;E21.4 0205. laryngo-pharyngectomy-free jejunum E19.1;E29.1'G03.2 0206. laryngo-pharyngectomy-pect major E19.1;E29.1;E21.4;S17.1;Y61.2 0207. total L-p-oesophagectomy+pullup E19.1;E29.1;G02.1 0208. creation of pharyngostome E23.8 0407. Excision lesion of tongue F23.1 0408. Tonsillectomy – unilateral F34.9 0810. Nasopharynx excision E24.1</p> <p><b>NECK DISSECTIONS</b> (USING WATKINSON OPCS CODE EXTENSIONS) 0301. NECK DISSECTION RADICAL T85.1 0302. NECK DISSECTION MODIFIED T85.1A 0303. modified Type I accessory preserved T85.1AI 0304. modified Type II accessory +IJV kept T85.1AII 0305. modified Type III sternomastoid,IJV + accessory kept T85.1AIII</p> <p>0307. SELECTIVE NECK DISSECTION (SND) T85.1B 0308. SND Level 1 (suprahyoid) T85.1BI 0309. SND Level 1–3 (supra omohyoid) T85.1BII 0310. SND Level 1–4 (anterolateral) T85.1BIII 0311. SND Level 2–4 (lateral) T85.1BIV 0312. SND Level 5 (posterior) T85.1BV 0313. SND Level 2–5 (posterolateral) T85.1BVI 0314. SND Level 6 (central compartment) T85.1BVII</p>
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## SURGERY (includes resective pathology)

			<p>T85.1BVIII T87.2</p> <p>LIP / ORAL CAVITY F38.1 F38.2 F23.1 F34.9 F39.1 F39.1 F39.1;S28.8 F39.1;S17.1;Y61.2 <b>F39.1;S20.8;Y59.2</b> F39.2;S35.3 V144 <b>V16.8</b> V14.3 V14.1 V14.2 F22.2 F22.1 <b>S17.1;Y61.2</b> <b>S17.1;Y63.8</b> S17.1;Y63.3 S17.1;Y63.1 S20.8;Y59.2 V19.1;Y66.2 <b>V19.1;Y66.2</b> V19.1;Y66.4;Y59.2 V19.1;Y66.6;Y59.8 V19.1;Y66.3;Y59.8 F32.4 <b>F32.8;Y05.1</b> F30.1 F30.2 F30.3 F30.5 F30.4 V07.2</p>	<p>0315. SND Level 7 (superior mediastinum) T85.1BVIII 0316. Excision or biopsy of cervical lymph node T87.2</p> <p><b>LIP / ORAL CAVITY</b> 0405. floor of mouth excision F38.1 0406. buccal mucosa excision F38.2 0407. excision lesion of tongue F23.1 0408 Tonsillectomy unilateral F34.9 0409. reconstruction mouth – with flap F39.1 0410. with primary closure F39.1 0411. with buccal flap F39.1;S28.8 0412. with pect major F39.1;S17.1;Y61.2 <b>0413. with radial forearm F39.1;S20.8;Y59.2</b> 0414. reconstruction mouth with SSG F39.2;S35.3 0415 Excision lesion jaw NEC V144 0416. mandibulotomy/split/division of jaw V16.8 0417. marginal mandibulectomy V14.3 0418. hemimandibulectomy V14.1 0418B.mandibulectomy, extensive V14.2 0419. partial glossectomy F22.2 0420. total glossectomy F22.1 <b>0421. Pectoralis major–skin and muscle S17.1;Y61.2</b> <b>0421B– muscle S17.1;Y63.8</b> 0422. Latissimus dorsi – skin and muscle S17.1;Y63.3 0422. B– muscle S17.1;Y63.1 0423. Radial forearm fasciocutaneous S20.8;Y59.2 0424. Reconstruction mandible V19.1;Y66.2 <b>0425 – with rib V19.1;Y66.2</b> 0426. - radius V19.1;Y66.4;Y59.2 0427. – with fibula V19.1;Y66.6;Y59.8 0428. – with iliac crest V19.1;Y66.3;Y59.8 0429. Palatectomy, partial, uvulectomy F32.4 <b>0430. Palatectomy, total F32.8;Y05.1</b> 0431. repair palate using palatal flap F30.1 0432. repair of palate using skin flap F30.2 0433. repair of palate using tongue flap F30.3 0434. repair of palate using mucosal flap F30.5 0435. repair of palate using skin graft F30.4 0802 Maxillectomy V07.2</p>
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## SURGERY (includes resective pathology)

			<p><b>SALIVARY GLAND</b>  F44.5  F44.4  F44.2  F44.1</p> <p><b>GENERAL</b>  S17.1;Y63.8  S17.1;Y61.2  S17.1;Y63.1  S17.1;Y61.3  S20.8;Y59.2  A30  A30.4  A30.8  A30.8  S17.1;Y61.2  S17.1;Y63.8  S17.1;Y61.3  S17.1;Y63.1  S20.8;Y59.2  S18.1;Y59.8  S17.3;Y61.5  S24.8;Y63.8</p> <p><b>NUTRITIONAL PROCEDURES</b>  Single Value</p> <p>N02  N06  N06B  N01</p>	<p><b>SALIVARY GLAND</b>  0601. sublingual gland excision F44.5  0602. submandibular gland excision F44.4  0603. parotidectomy, superficial F44.2  0604. parotidectomy, total F44.1</p> <p><b>GENERAL</b>  0421B. Pectoralis major - muscle S17.1;Y63.8  0421. Pectoralis major – skin and muscle S17.1;Y61.2  0422B. Latissimus dorsi – muscle S17.1;Y63.1  0422. Latissimus dorsi – skin and muscle S17.1;Y61.3  0423. Radial forearm fasciocutaneous S20.8;Y59.2  1001. Repair of cranial nerve A30  1002. Repair of cranial nerve – repair of facial nerve A30.4  1003. Repair of cranial nerve – repair of accessory nerve A30.8  1004. Repair of cranial nerve – repair of hypoglossal nerve A30.8  1005. Pectoralis major – skin and muscle S17.1;Y61.2  1006. Pectoralis major – muscle S17.1;Y63.8  1007. Latissimus dorsi – skin and muscle S17.1;Y61.3  1008. Latissimus dorsi – muscle S17.1;Y63.1  1009. Radial forearm fasciocutaneous S20.8;Y59.2  1010. Anteriolateral thigh flap reconstruction S18.1;Y59.8  1011. Repair with rectus abdominus free flap – myocutaneous S17.3;Y61.5  10.12. Repair with rectus abdominus free flap – free muscle S24.8;Y63.8</p> <p><b>NUTRITIONAL PROCEDURES</b>  Mappable to OPCS–4  N02. Insertion oesophagogastric tube (via TEP) G08.3 Y53.8  N06. Radiologically inserted gastrostomy RIG (permanent) G34.1  Y53.1  N06B. Radiologically inserted gastrostomy RIG (temporary) G34.2  Y53.1  N01. Insertion gastrojejunal tube G38.3</p>
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## SURGERY (includes resective pathology)

			N12	G34.1 Y75.2 N12. Laparoscopically placed gastrostomy (permanent)	G34.1
			N12B	Y75.2 N12B. Laparoscopically placed gastrostomy (temporary)	G34.2
			N03	N03. Intubation of jejunum NEC	G67.4
			N11	N11. Insertion nasogastric tube	G47.8
			N04	N04. Percutaneous gastrostomy (permanent) PEG	G34.1 (permanent)
			N04B	N04B Percutaneous gastrostomy (temporary) PEG	G34.2 (temporary) + Y53.9
			N05	N05. Ultrasound guided gastrostomy	G34.1 (permanent)
			N05B	N05B. G34.2 (temporary) + Y53.2	
			N07	N07. Open gastrostomy	G34.1 (permanent)
			N07B	N07B G34.2 (temporary)	
			N08	N08. Oesophagostomy	G08.9
			N09	N09. Percutaneous jejunostomy (PEJ)	G60.1 Y53.9
			N10	N10. Open jejunostomy	G60.1
			N13	N13. Subclavian long line	L91.2
			N14	N14. Antecubital longline	L91.8
			N15	N15. Peripheral intravenous feeding	
			N16	N16. Portacath, permacath	L91.1
			N17	N17. Hickman Line	L91.1
			N00	N00 No procedure	
			DIAGNOSTIC PROCEDURES	DIAGNOSTIC PROCEDURES	
			Single value:		
			Separate using semi-colon (D01;D02)		
			D01	D01. EUA and biopsy mouth	F42.1
			D02	D02. EUA and biopsy tongue	F24.1
			D03	D03. EUA and biopsy palate	F32.1
			D04	D04. Biopsy mouth	F42.1
			D05	D05. Biopsy tongue	F24.1
			D06	D06. Biopsy palate	F32.1
			D07	D07. Direct laryngoscopy and biopsy	E36.1
			D08	D08. Microlaryngoscopy and biopsy	E36.1
			D09	D09. Pharyngoscopy and biopsy	E25.1
			D10	D10. Oesophagoscopy and biopsy (rigid)	G19.1
			D11	D11. Oesophagoscopy and biopsy (flexible)	G16.1
			D12	D12. Tracheoscopy	E51.9 + Z24.3 (rigid)

## SURGERY (includes resective pathology)

			D13	D13. Bronchoscopy	E49.9 (flexi)
			D15	D15. Bronchoscopy	E51.9 (rigid) + Z24.5
			D17	D17. Fine needle aspiration cytology cervical node	T86.1 + Y22.2
			D22	D22. EUA and biopsy nasopharynx (mirror) - OPEN	E27.1
			D26	D26. EUA and biopsy oropharynx- OPEN	E27.1
			D30	D30. Pharyngoscopy	E25.1
			D31	D31. Oesophagoscopy	G16.1 (flexi) G19.1 (rigid)
			D35	D35. Bronchoscopy – RIGID	E51.9 (rigid) + Z24.5
			D45	D45. FNA Cytology parotid	F58.1 + Y22.2
			D47	D47. Incisional biopsy cervical lymph node	T87.2
			D51	D51. <b>Tracheostomy (RIGID)</b>	E42.1
			D52	D52. Direct Laryngoscopy	E36.1
			D53	D53. EUA & Biopsy nasopharynx (mirror)	E10.1 (nose) E25.1 (endoscopically) E27.1 (open)
			D54	D54. EUA and biopsy nasopharynx (telescope) – ENDOSCOPICALLY	E25.1
			D55	D55. EUA & Biopsy nasopharynx (telescope) open	E27.1 (open)
			D56	D56. EUA & biopsy oropharynx – endoscopically	E25.1
			D57	D57. EUA & biopsy nasopharynx – (mirror) endoscopically	E25.1
			D58	D58. EUA nasopharynx (mirror) open	E27.1
			D59	D59. EUA nasopharynx (telescope) endoscopically	E25.1
			D60	D60. EUA nasopharynx (telescope) open	E27.1
			D61	D61. EUA oropharynx	E27.1 (open) E25.1 (endoscopically)
			D63	D63. FNA of sublingual gland	F46.3
			D64	D64. FNA of submandibular gland	F46.3
			D65	D65. Incisional biopsy lesion parotid	F48.1 + Z26.1
			D66	D66. Incisional biopsy sublingual gland	F46.3
			D67	D67. Incisional biopsy submandibular gland	F46.2
			D68	D68. Microlaryngoscopy	E36.1
				<b>Where it is not possible to distinguish between different procedures (D codes) with the same OPCS code use the following D codes as follows:</b>	
			D90	D90 Pharyngeal Endoscopy – E25.1	
			D91	D91 Biopsy Mouth unspecified – F42.1	
			D92	D92 Biopsy Tongue unspecified – F24.1	
			D93	D93 Biopsy Palate unspecified – F32.1	

## SURGERY (includes resective pathology)

				D94 D95 D96 D97 D98 D99	D94 Laryngoscopy unspecified – E36.1 D95 Oesophagoscopy (rigid) unspecified – G19.1 D96 Sampling Submandibular gland – F46.2 D97 Nasopharyngeal endoscopy – E27.1 D98 Oesophagoscopy unspecified – G16.1 D99 Sampling Sublingual Gland – F46.3
11	7.11	Secondary procedure code (s) (Other procedure)		See Primary (Main) Procedure (above)	Text field – single value Coded item to record secondary procedure(s). Coding as for Primary (Main) Procedure.
12	7.11	Secondary procedure code (s) (Other procedure)			Text field – single value Coded item to record secondary procedure(s). Coding as for Primary (Main) Procedure.
13	7.11	Secondary procedure code (s) (Other procedure)			Text field – single value Coded item to record secondary procedure(s). Coding as for Primary (Main) Procedure.
14	7.11	Secondary procedure code (s) (Other procedure)			Text field – single value Coded item to record secondary procedure(s). Coding as for Primary (Main) Procedure.
15	7.11	Secondary procedure code (s) (Other procedure)			Text field – single value Coded item to record secondary procedure(s). Coding as for Primary (Main) Procedure.

## SURGERY (includes resective pathology)

16	7.13	Discharge destination			<p>Text field – single value Coded item to record the destination of the patient on completion of the hospital stay.</p> <p>19. Usual place of residence, unless listed below, for example, a private dwelling whether owner occupied or owned by local authority, housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes patients with no fixed abode.</p> <p>29. Temporary place of residence when usually resident elsewhere (includes hotel, residential educational establishment)</p> <p>30. Repatriation from a High Security Psychiatric Hospital</p> <p>37. Court</p> <p>38. Penal establishment or police station</p> <p>48. High Security Psychiatric Hospital, Scotland</p> <p>49. High Security Psychiatric Hospital, England</p> <p>50. NHS hospital provider - medium secure unit</p> <p>51. NHS hospital provider - ward for general patients or the younger physically disabled</p> <p>52. NHS hospital provider - ward for maternity patients or neonates</p> <p>53. NHS hospital provider - ward for patients who are mentally ill or have learning disabilities</p> <p>54. NHS run nursing home, residential care home or group home</p> <p>65. Local Authority Part 3 residential accommodation, i.e. where care is provided</p> <p>66. Local Authority foster care, but not in Part 3 residential accommodation</p> <p>79. Patient died or stillbirth</p> <p>84. Non-NHS run hospital - medium secure unit</p> <p>85. Non-NHS (other than Local Authority) run residential care home</p> <p>86. Non-NHS (other than Local Authority) run nursing home</p> <p>87. Non-NHS run hospital</p> <p>88. Non-NHS (other than Local Authority) run Hospice</p> <p>98. Not applicable - hospital provider spell not finished at episode end (i.e. not discharged, or current episode unfinished)</p> <p>99 – Not known</p>
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## SURGERY (includes resective pathology)

17	4.2	Primary Site Tumour	Yes	<p><b>ORAL CAVITY</b></p> <p>C00.3 C00.4 C06.0 C06.1 C06.2 C03.0 C03.1 C04.0 C04.1 C04.8 C05.0 C02.0 C02.1 C02.2 C02.8 C02.3 C06.8</p> <p><b>OROPHARYNX</b></p> <p>C09.0 C09.1 C09.9 C10.2 C01 C10.0</p> <p>C10.3 C05.1 C05.2 C02.4 C05.8 C10.8 <b>C10.9</b></p>	<p>Text field – single value The main cancer site for which the patient is receiving care. ICD-10 Coding, where:</p> <p><b>ORAL CAVITY</b></p> <p>C00.3 Lip, inner aspect, mucosa of upper C00.4 Lip, inner aspect, mucosa of lower C06.0 Cheek mucosa C06.1 Mouth, vestibule (buccal sulcus and labial) C06.2 Retromolar trigone C03.0 Gum, upper (alveolar ridge, mucosa, gingiva) C03.1 Gum, lower (alveolar ridge, mucosa, gingiva) C04.0 Mouth, anterior floor C04.1 Mouth, lateral floor C04.8 Mouth, floor, overlapping lesion C05.0 Palate, hard C02.0 Tongue, dorsal surface, anterior 2/3 C02.1 Tongue, lateral border, tip of tongue C02.2 Tongue, ventral, inferior surface C02.8 Tongue, overlapping lesion of anterior two-third C02.3 Anterior two-thirds of tongue, part unspecified C06.8 Overlapping lesion of other and unspecified parts of mouth</p> <p><b>OROPHARYNX</b></p> <p>C09.0 Tonsillar fossa C09.1 Tonsillar pillar, glossotonsillar sulcus C09.9 Tonsil, not otherwise specified C10.2 Lateral wall oropharynx C01 Base of tongue C10.0 Vallecula (Anterior surface epiglottis – see supraglottic larynx) C10.3 Posterior wall oropharynx C05.1 Palate, soft, inferior surface C05.2 Uvula C02.4 Lingual tonsil C05.8 Overlapping lesion palate C10.8 Overlapping lesion of oropharynx <b>C10.9 Orpoharynx unspecified</b></p>
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## SURGERY (includes resective pathology)

			<p><b>NASOPHARYNX</b>  C11.0  C11.1  C11.2  C11.3  C11.8  C11.9</p> <p><b>HYPOPHARYNX</b>  C12.x or C.12.9  C13.0  C13.1  C13.2  C13.8  C13.9</p> <p><b>LARYNX</b></p> <p>C32.1  C10.1  C32.1A  C32.1B  C32.3A  C32.1D  C32.1E</p> <p>C32.0  C32.0B  C32.0C  C32.9  C32.0A</p> <p>C32.2  C32.3  C32.3B  C32.3C</p>	<p><b>NASOPHARYNX</b>  C11.0 Nasopharynx, roof  C11.1 Nasopharynx, posterior wall  C11.2 Nasopharynx, lateral wall, fossa of Rosenmuller  C11.3 Nasopharynx, inferior, upper surface soft palate  C11.8 Nasopharynx, overlapping lesion  C11.9 <b>Nasopharynx unspecified</b></p> <p><b>HYPOPHARYNX</b>  C12.x or c.12.9 Pyriform sinus  C13.0 Postcricoid region  C13.1 Aryepiglottic fold, hypopharyngeal aspect  C13.2 Hypopharynx, posterior wall  C13.8 Hypopharynx, overlapping lesion  C13.9 <b>Hypopharynx unspecified</b></p> <p><b>LARYNX</b></p> <p>Supraglottis – subsite OPTIONAL BAHNO SUPPLEMENTARY CODES  C32.1 Supraglottis  C10.1 Anterior surface epiglottis  C32.1A Suprahyoid epiglottis (tip, laryngeal surface)  C32.1B Aryepiglottic fold, laryngeal aspect  C32.3A Arytenoid  C32.1D Infrahyoid epiglottis  C32.1E False cords</p> <p>**Glottis – subsite OPTIONAL BAHNO SUPPLEMENTARY CODES  C32.0 Glottis  C32.0B Anterior commissure  C32.0C Posterior commissure  C32.9 Larynx, not otherwise specified  C32.0A <b>Vocal cords</b></p> <p>Subglottis  C32.2 Subglottis  C32.3 Laryngeal cartilage  C32.3B Cricoid cartilage  C32.3C Thyroid cartilage</p>
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## SURGERY (includes resective pathology)

				<b>MAJOR SALIVARY GLANDS</b> C07.x or C07.9 C08.0 C08.1	<b>MAJOR SALIVARY GLANDS (for minor refer to anatomic site found)</b> C07.x Or C07.9 Parotid gland C08.0 Submandibular, submaxillary gland C08.1 Sublingual gland
18		TNM stage category (pathological)			Derived value
19	8.16	Tumour site T category (pathological) pT		<b>See Care Plan, Appendix B of dataset or UICC 6<sup>th</sup> Edition</b>	Text field – single value. The 'T' part of the TNM classification UICC Coding (6 <sup>th</sup> Edition) <i>A full description of the UICC coding (6<sup>th</sup> Edition) can be found in Care Plan</i>
20	8.17	Tumour site N category (pathological) pN		<b>See Care Plan, Appendix B of dataset or UICC 6<sup>th</sup> Edition</b>	Text field – single value. The 'N' part of the TNM classification UICC Coding (6 <sup>th</sup> Edition)
21	8.18	Tumour site M category (pathological) pM		M0 M1 MX	Text field – single value. The 'M' part of the TNM classification UICC Coding (6 <sup>th</sup> Edition)
22	8.3	Date of Pathology Report		DD/MM/YYYY	Date format including forward slash
23	8.10	Histology		<b>Squamous carcinoma and variants</b> M8070/3 M8071/3 M8072/3 M8074/3 M8075/3 M8560/3 M8051/3  <b>Salivary malignancies</b> M8550/3 M8430/3 M8200/3 M8525/3	Text field – single value, where: <b>Squamous carcinoma and variants</b> M8070/3 Squamous carcinoma (Not Otherwise Specified) M8071/3 Keratinising squamous carcinoma M8072/3 Non-keratinising squamous carcinoma M8074/3 Spindle cell squamous carcinoma M8075/3 Adenoid squamous carcinoma M8560/3 Adenosquamous carcinoma M8051/3 Verrucous carcinoma (Note M-8070/6, Squamous carcinoma, metastatic, not otherwise specified removed)  <b>Salivary malignancies</b> M8550/3 Acinic cell carcinoma M8430/3 Mucoepidermoid carcinoma M8200/3 Adenoid cystic carcinoma M8525/3 Polymorphous low grade adenocarcinoma (terminal duct adenocarcinoma)

## SURGERY (includes resective pathology)

				M8562/3 M8147/3 M8480/3 M8500/3 M8140/3 M8941/3 M8070/3 M8041/3 M8020/3	M8562/3 Epithelial-myoepithelial carcinoma M8147/3 Basal cell adenocarcinoma M480/3 Mucinous adenocarcinoma M8500/3 Salivary duct carcinoma M8140/3 Adenocarcinoma M8941/3 Carcinoma in pleomorphic adenoma (malignant mixed tumour) M8070/3 Squamous carcinoma (Not Otherwise Specified) M8041/3 Small cell carcinoma M8020/3 Undifferentiated carcinoma
24	8.13	Excision margin		A B C D U 8	A. Margin involved B. < 1mm clear C. 1–5 mm clear D. > 5 mm clear U. Uncertain 8. Not applicable (default)

# TELETHERAPY

## TELETHERAPY.CSV

CSV Field No	Dataset Ref	Field Name	Mandatory	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Numeric National 10 digit NHS number
2		Hospital identifier (Submitting organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s)
3	1.3	Hospital identifier (Contact organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient
4	1.2	Patient case record number		Any value / format	Text field – single value Local to each organisation
5	4.1	Date of Diagnosis	Yes	DD/MM/YYYY	Date format including forward slash. Included for data integrity purposes, to ensure correct linking of files.
6	5.3	Care Plan agreed date	Yes	DD/MM/YYYY	Date format including forward slash
7	10.3	Date teletherapy decision		DD/MM/YYYY	Date format including forward slash
8	10.6	Cancer treatment intent		C P A N 9	Text field – single value Coded item to record the intention of the treatment, where: C. Curative P. Palliative A. Adjuvant N. Neoadjuvant 9. Not known (default)
9	HN.25	Teletherapy treatment to		A M O P PR R	A. Non-anatomically specific primary site M. Metastasis O. Prophylactic (to non-primary site) P. Primary PR. Primary & Regional Nodes R. Regional Nodes
10	10.7	Radiotherapy treatment site		Z65 Z30.1 Z52.8 Z63.8 Z87.1 Z92.1 Z92.3	Only to be completed for codes A, O and M above. OPCS4 'Z' code for anatomical site Z65 – Jaw Z30.1 – Liver Z52.8 – Thorax (Specified chest wall nec) Z63.8 – Skull base (Specified bone of cranium nec) Z87.1 – Bone Z92.1 – Head Z92.3 – Neck

## TELETHERAPY

				Z92.4 Z92.6	Z92.4 – Chest Z92.6 – Abdomen nec
11	10.8	Teletherapy start date	Yes	DD/MM/YYYY	Date format including forward slash

# BRACHYTHERAPY

## BRACHYTHERAPY.CSV

CSV Field No	Dataset Ref	Field Name	Mandatory	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Numeric National 10 digit NHS number
2		Hospital identifier (Submitting organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s)
3	1.3	Hospital identifier (Contact organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient
4	1.2	Patient case record number		Any value / format	Text field – single value Local to each organisation
5	4.1	Date of Diagnosis	Yes	DD/MM/YYYY	Date format including forward slash. Included for data integrity purposes, to ensure correct linking of files.
6	5.3	Care Plan agreed date	Yes	DD/MM/YYYY	Date format including forward slash
7	11.3	Date brachytherapy decision		DD/MM/YYYY	Date format including forward slash
8	11.6	Cancer treatment intent		C P A N 9	Text field – single value Coded item to record the intention of the treatment, where: C. Curative P. Palliative A. Adjuvant N. Neoadjuvant 9. Not known (default)
9	HN.26	Brachytherapy treatment to		A M O P PR R	A. Non-anatomically specific primary site M. Metastasis O. Prophylactic (to non-primary site) P. Primary PR. Primary & Regional Nodes R. Regional Nodes
10	10.7	Radiotherapy Treatment Site		Z65 Z30.1 Z52.8 Z63.8 Z87.1 Z92.1	Only to be completed for codes A, O and M above. OPCS4 'Z' code for anatomical site Z65 – Jaw Z30.1 – Liver Z52.8 – Thorax (Specified chest wall nec) Z63.8 – Skull base (Specified bone of cranium nec) Z87.1 – Bone Z92.1 – Head

## BRACHYTHERAPY

				Z92.3 Z92.4 Z92.6	Z92.3 – Neck Z92.4 – Chest Z92.6 – Abdomen nec
11	11.9	Brachytherapy start date	Yes	DD/MM/YYYY	Date format including forward slash

# CHEMOTHERAPY

## CHEMOTHERAPY.CSV

CSV Field No	Dataset Ref	Field Name	Mandatory	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Text field National 10 digit NHS
2		Hospital identifier (Submitting organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s)
3	1.3	Hospital identifier (Contact organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient
4	1.2	Patient case record number		Any value / format	Text field – single value Local to each organisation
5	4.1	Date of Diagnosis	Yes	DD/MM/YYYY	Date format including forward slash. Included for data integrity purposes, to ensure correct linking of files.
6	5.3	Care Plan agreed date	Yes	DD/MM/YYYY	Date format including forward slash
7	9.4	Date Chemotherapy decision to treat		DD/MM/YYYY	Date format including forward slash
8	9.7	Chemotherapy drug type		C H I O	Text field – single value Coded item to record the drug type, where: C. Chemotherapy H. Hormone/endocrine therapy I. Immunotherapy O. Other
9	9.8	Chemotherapy drug treatment intent		C P A N 9	Text field – single value Coded item to record the drug type, where: C. Curative P. Palliative A. Adjuvant N. Neoadjuvant 9. Not known (default)
10	9.10	Chemotherapy start date	Yes	DD/MM/YYYY	Date format including forward slash

# STATUS

## STATUS.CSV

CSV Field No	Dataset Ref	Field Name	Mandatory	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Numeric National 10 digit NHS number
2		Hospital identifier (Submitting organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s)
3	1.3	Hospital identifier (Contact organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient
4	1.2	Patient case record number		Any value / format	Text field – single value Local to each organisation
5	4.1	Date of Diagnosis	Yes	DD/MM/YYYY	Date format including forward slash. Included for data integrity purposes, to ensure correct linking of files.
6	14.1	Clinical status assessment date	Yes	DD/MM/YYYY	Date format including forward slash
7	14.2	Primary tumour status		1 2 3 4 5	Text field – single value Coded item to record the status of the primary tumour at this contact, where: 1. Residual Primary Tumour 2. No Evidence of Primary Tumour 3. Recurrent Primary Tumour 4. Not assessed 5. Uncertain
8	14.3	Nodal status		1 2 3 4 5	Text field – single value Coded item to record the status of the nodal metastases at this contact, where: 1. Residual Regional Nodal Metastases 2. No Evidence of Regional Nodal Metastases 3. New Regional Nodal Metastases 4. Not assessed 5. Uncertain
9	14.4	Metastatic status		1 2 3 4 5 9	Text field – single value Coded item to record the status of the distant metastases at this contact, where: 1. Residual Distant Metastases 2. No Evidence of Metastases 3. New Distant Metastases 4. Not assessed 5. Uncertain – immediately post treatment 9. Not known (default)

## STATUS

10	14.10	Morbidity code chemotherapy		2 3 4 5	Coded item to record any morbidity, relevant to previous chemotherapy treatments that the patient has received, recorded at any subsequent patient contact, where: 2. mild toxicity 3. moderate toxicity 4. severe toxicity 5. Death due to toxicity
11	14.11	Morbidity code radiotherapy		2 3 4 5	Coded item to record any morbidity, relevant to previous radiotherapy treatments that the patient has received, recorded at any subsequent patient contact, where: 2. mild toxicity 3. moderate toxicity 4. severe toxicity 5. Death due to toxicity
12	14.12	Morbidity code combination		2 3 4 5	Coded item to record any morbidity, relevant to previous combination treatments that the patient has received, recorded at any subsequent patient contact, where: 2. mild toxicity 3. moderate toxicity 4. severe toxicity 5. Death due to toxicity

# MORTALITY

## MORTALITY.CSV

CSV Field No	Dataset Ref	Field Name	Mandatory	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Numeric National 10 digit NHS number
2		Hospital identifier (Submitting organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s)
3	1.3	Hospital identifier (Contact organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient
4	1.2	Patient case record number		Any value / format	Text field – single value Local to each organisation
5	15.1	Date of death	Yes	DD/MM/YYYY	Date format including slash

## SVR

### SURGICALVOICERESTORATION.CSV (including SWALLOWINGASSESSMENT)

CSV Field No	Dataset Ref	Field Name	Mandatory	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Numeric National 10 digit NHS number
2		Hospital identifier (Submitting organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s)
3	1.3	Hospital identifier (Contact organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient
4	1.2	Patient case record number		Any value / format	Text field – single value Local to each organisation
5	4.1	Date of Diagnosis	Yes	DD/MM/YYYY	Date format including forward slash. Included for data integrity purposes, to ensure correct linking of files.
6	5.3	Care Plan agreed date	Yes	DD/MM/YYYY	Date format including forward slash
7	HN.23	Contact date [Date of contact]		DD/MM/YYYY	Date format including forward slash
8	S1	Speech & swallowing assessment date		DD/MM/YYYY	Date format including forward slash
9	S2	Normalcy of Diet [Post Treatment]		ND1 ND2 ND3 ND4 ND5 ND6 ND7 ND8 ND9 ND10 ND11	Text field – single value ND1. Full diet with no restrictions 100 ND2. Full diet with liquid assistance 90 ND3. All meats 80 ND4. Carrots, celery (crunchy) 70 ND5. Dry bread and crackers 60 ND6. Soft, chewable foods (pasta) 50 ND7. Soft foods requiring no chewing 40 ND8. Puree 30 ND9. Warm liquids 20 ND10. Cold liquids 10 ND11. Non oral 0
10	SVR.3	SVR contact professional involvement [Who actioned contact]		D N S	Text field – single value D-Doctor N-Nurse S-SALT
11	SVR.5	SVR contact purpose (Type of contact)		01 02	Text field – single value 01. Pre-op assessment by SALT 02. Voice prosthesis fitting-initial

## SVR

				03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18	03. Voice prosthesis change (replacement of same type) 04. Voice prosthesis fitting – other 05. Voice prosthesis troubleshooting 06. Voice / Voice prosthesis management (voice work and/or care of valve) 07. Stoma management 08. Oesophageal voice management 09. Eletrolarynx voice management 10. Mouthing training 11. Post-op counselling 12. General review 13. Swallowing related intervention 14. Hands free tracheostoma valve management 15. Temporary planned voice prosthesis removal 16. Temporary accidental voice prosthesis removal 17. Voice prosthesis removal – permanent 18. Other
12	SVR.7	Patient follow-up status [Follow-up status]		1 2 3 4 5 6 9	Text field – single value 1. Under follow-up 2. Lost to follow up 3. Discharged 4-. Transferred to another unit for SVR care 5. Inactive case 6. Died 9. Not known
13	SVR.8	SVR communication post operative method [Proposed method of post- operative communication]		9 E O M W PSVR SSVR	Text field – single value 9. Not known (indicates that SALT did not do pre-op assessment) E. Electrolarynx O. Oesophageal voice M. Mouthing W. Writing or AAC aid PSVR Primary SVR SSVR Secondary SVR
14	SVR.9	SVR communication primary method [primary method of communication at contact]		VP VS E O M W	Text field – single value VP. Voice prosthesis professionally changed. VS. Voice prosthesis self changed. E. Elecrolarynx O. Oesophageal voice M. Mouthing W. Writing or AAC aid

## SVR

15	SVR.10	SVR communication other method [Other methods of communication]		VP VS E O M W	Text field – single value VP. Voice prosthesis professionally changed. VS. Voice prosthesis self changed. E. Electrolarynx O. Oesophageal voice M. Mouthing W. Writing or AAC aid
16	SVR.11	Post operative voicing [Post-operative voicing]		1 2 3 4 8	1. Functional valve 2. Non-functional valve 3. Functional oesophageal 4. Non-functional oesophageal 8. Not applicable
17	SVR.12	SVR permanent valve removal reason (reason for permanent removal)		1 2 3 4 5	1. Patient choice 2. Peripheral leak 3. Other unmanageable complication 4. No voice/non-functional voice 5. Other

# NUTRITION

## NUTRITIONAL.CSV

CSV Field No	Dataset Ref	Field Name	Mandatory	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Numeric National 10 digit NHS number
2		Hospital identifier (Submitting organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s)
3	1.3	Hospital identifier (Contact organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient
4	1.2	Patient case record number		Any value / format	Text field – single value Local to each organisation
5	4.1	Date of Diagnosis	Yes	DD/MM/YYYY	Date format including forward slash. Included for data integrity purposes, to ensure correct linking of files.
6	D10	Patient estimated normal weight (Kg)		nnn.nnn	Number field (nnn.nnn)
7	D1	Person observation (weight) (Kg)		nnn.nnn	Number (nnn.nnn)
8	D2	Date weight measured		DD/MM/YYYY	Date format including forward slash
9	D3	Person observation (height) (M)		n.nn	Number field (n.nn)
10	D4	Date height measured		DD/MM/YYYY	Date format including forward slash
11	D5	Contact date dietician post treatment		DD/MM/YYYY	Date format including forward slash
12	HN.19	Contact date (dietitian initial)	Yes	DD/MM/YYYY	Date format including forward slash
13	D6	Date nutritional support instigated		DD/MM/YYYY	Date format including forward slash
14	D7	Nutritional Support Type		9 E O P	Text – single value 9. Not known E. Enteral O. Oral supplements only P. Parenteral
15	D8	Date nutritional support remains in place		DD/MM/YYYY	Date format including forward slash
16	D9	Date nutritional		DD/MM/YYYY	Date format including forward slash

## NUTRITION

support withdrawn				
17	7.9	Procedure date [Date nutritional procedure]	DD/MM/YYYY	Date format including forward slash
18	7.11	Procedure (OPCS) [Nutritional Procedure Type]	N02 N06 N06B N01  N12 N12B N03 N11 N04 N04B N05 N05B N07 N07B N08 N09 N10 N13 N14 N15 N16 N17 N00	Text field – single value Mappable to OPCS–4 N02. Insertion oesophagogastric tube (via TEP) G08.3 Y53.8 N06. Radiologically inserted gastrostomy RIG (permanent) G34.1 Y53.1 N06B. Radiologically inserted gastrostomy RIG (temporary) G34.2 Y53.1 N01. Insertion gastrojejunal tube G38.3 G34.1 Y75.2 N12. Laparoscopically placed gastrostomy (permanent) G34.1 Y75.2 N12B. Laparoscopically placed gastrostomy (temporary) G34.2 Y75.2 N03. Intubation of jejunum NEC G67.4 N11. Insertion nasogastric tube G47.8 N04. Percutaneous gastrostomy (permanent) PEG G34.1 (permanent) N04B Percutaneous gastrostomy (temporary) PEG G34.2 (temporary) + Y53.9 N05. Ultrasound guided gastrostomy G34.1 (permanent) N05B. G34.2 (temporary) + Y53.2 N07. Open gastrostomy G34.1 (permanent) N07B G34.2 (temporary) N08. Oesophagostomy G08.9 N09. Percutaneous jejunostomy (PEJ) G60.1 Y53.9 N10. Open jejunostomy G60.1 N13. Subclavian long line L91.2 N14. Antecubital longline L91.8 N15. Peripheral intravenous feeding N16. Portacath, permacath L91.1 N17. Hickman Line L91.1 N00 No procedure

# PALLIATIVE

## PALLIATIVE.CSV

CSV Field No	Dataset Ref	Field Name	Mandatory	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Numeric National 10 digit NHS number
2		Hospital identifier (Submitting organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s)
3	1.3	Hospital identifier (Contact organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient
4	1.2	Patient case record number		Any value / format	Text field – single value Local to each organisation
5	4.1	Date of Diagnosis	Yes	DD/MM/YYYY	Date format including forward slash. Included for data integrity purposes, to ensure correct linking of files.
6	5.3	Care Plan agreed date	Yes	DD/MM/YYYY	Date format including forward slash
7	12.1	Date palliative decision	Yes	DD/MM/YYYY	Date format including forward slash
8	12.2	Palliative care start date		DD/MM/YYYY	Date format including forward slash

# NURSING

## NURSING.CSV

CSV Field No	Dataset Ref	Field Name	Mandatory	Permitted Value	Description
1	1.1	NHS number	Yes	10 digit number	Numeric National 10 digit NHS number
2		Hospital identifier (Submitting organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit submitting the patient record(s)
3	1.3	Hospital identifier (Contact organisation)	Yes	5 characters	5 character National NHS organisation site code of the Unit seeing the patient or providing diagnosis or care to the patient
4		Patient case record number		Any value / format	Text field – single value Local to each organisation
5	4.1	Date of Diagnosis	Yes	DD/MM/YYYY	Date format including forward slash. Included for data integrity purposes, to ensure correct linking of files.
6	ClinNS1	Source of referral for cancer to ClinNS [Source of referral to ClinNS]		M C H O U	Text field – single value M. Head and neck multidisciplinary team member C. Outside MDT community based H. Outside MDT hospital based O. Other U. Unknown
7	ClinNS2	Cancer referral decision date to ClinNS [Date of decision to refer to ClinNS]		DD/MM/YYYY	Date format including forward slash
8	ClinNS3	Reason for referral to ClinNS		N T C O U	N. New diagnosis T. Treatment options / decision support C. Complex problems O. Other U. Unknown
9	ClinNS4	Contact date (ClinNS initial) [Dte of first assessment with ClinNS]		DD/MM/YYYY	Date format including forward slash
10	ClinNS5	Date patient advised of cancer diagnosis		DD/MM/YYYY	Date format including forward slash
11	ClinNS6	Professionals			Text field – multi-value

## NURSING

		present at breaking of bad news		D C M N G O U	D. Designated head neck surgeon/oncologist or designate C. Clinical nurse specialist or designate M. Non designated doctor N. Non designated nurse G. General practitioner O. Other U. Unknown
12	ClinNS7	Date of ClinNS intervention	Yes	DD/MM/YYYY	Date format including forward slash
13	ClinNS8	Type of ClinNS intervention		1 2 3 4 5 6 7 8 9	Text field - multi value 1. Assessment 2. Information and advice 3. Decision making support 4. .Psychological support 5. Technical/practical 6. Discharge planning/after treatment support 7. Liaison/referral 8. Benefits grants 9. Not known
14	ClinNS9	Date of discharge from ClinNS		DD/MM/YYYY	Date format including forward slash