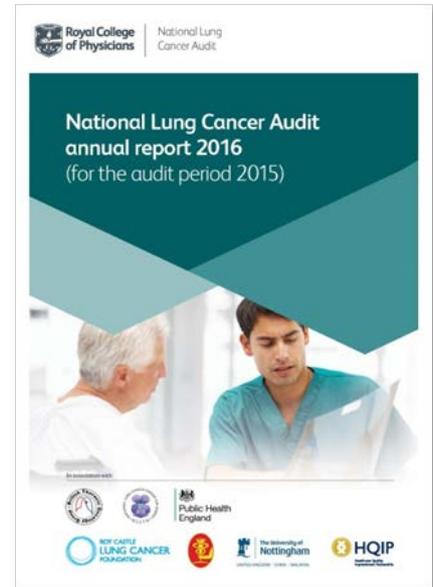


National Lung Cancer Audit toolkit

Improving lung cancer care

Staff working in lung cancer teams want to deliver the best care possible for their patients, but the National Lung Cancer Audit (NLCA) analysis shows marked variation in standards of care across different organisations, indicating that this may not always be the case. In the 2016 annual report, we make 13 recommendations to improve care, and here we provide a toolkit to help organisations achieve them.



Data quality



Treatment



Pathology



Surgery



Specialist nursing



Chemotherapy

The NLCA team are always happy to discuss your results, and to offer advice on data collection and service improvement. We may be able to facilitate peer-to-peer assistance in some cases. Visit www.rcplondon.ac.uk/nlca

The full NCLA annual report is available at www.rcplondon.ac.uk/nlca2016

Commissioned by:



Royal College
of Physicians

National Lung
Cancer Audit



HQIP

Healthcare Quality
Improvement Partnership

01 Data quality

Appoint a **clinical data lead** to take responsibility for understanding the dataset and the data collection process.

Raise the profile of performance data across the wider MDT at governance meetings or by sharing data.

Use **CancerStats** website to review data quality in real time.

Integrate data collection into **MDT meetings**.

Integrate **clinical validation** into the Cancer Outcomes and Services Dataset (COSD) submission process.

Check that **key fields** are completed prior to COSD submission.

Work with National Cancer Registration and Analysis Service (NCRAS) **data improvement leads** to understand cases **missed by COSD**.

Improve the quality of data submitted to the NLCA.

PS and stage should be recorded in at least **90%** of cases.

Complete the FEV1 and FEV1% fields in relevant patients.

Ensure that the COSD 'place first seen' is completed in all submissions.



At least 80% of cases should be confirmed using pathological methods.

Non-small-cell lung cancer (NSCLC) not otherwise specified (NOS) rates of more than 15% should be reviewed.



02 Pathology

This result should be interpreted in conjunction with the **casemix-adjusted odds ratio**, which might better reflect whether the organisation is an outlier.

Ensure that all pathological diagnoses are submitted to the audit, including those confirmed only by resection. Liaise with the **pathology department** to identify cases.

Review clinical diagnoses and diagnostics protocols if pathological confirmation rate is below optimum.

Ensure that the **pathologist** is an integral part of the lung MDT and understands the importance of **tumour subtyping**.

Ensure that RCPATH guidelines are being followed for the reporting of lung cancer samples, including the use of a limited panel of **immunohistochemical markers** for subtyping where necessary.

03 Nursing

Ensure that the LCNS **establishment** is appropriate to the lung cancer **workload**.

Ensure that all nursing posts are **staffed**.

Review the activities of the nursing team and **reduce administrative burden**.

Involve nurses in the **validation** of data submissions, including checking that all **activity is captured** prior to submission.

Ensure that **clear pathways** exist for referral for LCNS input (especially important for **inpatients**).

At least 90% of patients are seen by a lung cancer nurse specialist (LCNS).

At least 80% of patients should have a lung cancer nurse specialist present at the time of diagnosis.



MDTs with low active anticancer treatment rates and low radical treatment rates should perform detailed case-note review to determine the reasons why patients with good performance status did not receive the most effective treatment option.



04 Treatment

Ensure that data on **all treatments** are submitted to the audit.

Review **treatment policies** for small-cell lung cancer patients.

Review **pathway** from diagnosis to treatment to ensure that it is as **expeditious** as possible.

Ensure that good **pathways** exist for access to **modern radiotherapy** treatments.

Take part in the planned **spotlight audit** of curative treatment in 2017.

05 Surgery

Ensure that **all surgical resections** are submitted to the audit.

If data are complete, then review **treatment policies** for early-stage lung cancer in patients with good performance status.

Ensure that the **thoracic surgeon attends** MDT meetings.

Provide a mechanism for access to a **second surgical opinion**.

Take part in the planned **spotlight audit** of curative treatment in 2017.

MDTs with low resection rates for NSCLC should perform detailed case-note review to determine why each resectable patient did not receive an operation, including whether a second opinion was offered to borderline-fit patients.



MDTs with low chemotherapy rates for NSCLC or SCLC should perform detailed case-note review to determine the reasons why each patient did not receive systemic anticancer treatment.

Patients with small-cell lung cancer should receive chemotherapy within 2 weeks of pathological diagnosis.



06 Chemotherapy

Ensure that data on **all treatments** are submitted to the audit.

Review treatment **policies** for patients.

Submit data on patients who do not have chemotherapy to '**significant event audit**' to explore themes.

Review **pathway** from diagnosis to treatment to ensure that patients with **SCLC** can access treatment within **2 weeks**.

Review **information/messages** given to patients and carers on the **benefits** of chemotherapy.

Ensure that tumours are subjected to appropriate **molecular testing** to ensure that all treatment options can be considered.

Recommendations

We make a number of specific recommendations for the next round of audit:

DATA COMPLETENESS	STANDARD
Case ascertainment	95%
Valid performance status (PS) and stage	≥90%
Patients with stage I–II and PS 0–1, completeness for FEV1 and FEV1%	>75%
PROCESS	
Proportion of patients seen by lung CNS	≥90%
Proportion of patients where lung CNS present for diagnosis	≥80%
Proportion of patients with pathological confirmation of lung cancer	≥80%
Proportion of patients where the pathology code is NSCLC NOS	<15%
Proportion of patients receiving PET-CT scan before surgery or radical radiotherapy	≥90%
Proportion of patients receiving chemotherapy for SCLC starting treatment within 2 weeks of pathological diagnosis	≥80%
TREATMENT AND OUTCOME	
The casemix-adjusted odds ratio will be used to determine outlier status, but organisations can use the 2015 mean results (shown below) as a guide to performance	
	2015 mean
Active anticancer treatment rates for patients	60%
Surgical resection rates for NSCLC patients	17%
Radical treatment rates for patients with stage I/II NSCLC	70%
Chemotherapy rates for SCLC	≥ 69%
Systemic anticancer treatment rates for PS (0–1) stage IIIB/IV NSCLC	64%
1-year survival	38%

In 2017, the NLCA will be building on QI initiatives and support for lung cancer teams. An online portal is under development, which will enable the collection of additional data items to better understand and address variation in surgical treatment and curative treatment rates across England. Alongside this, the NLCA team will be delivering regional workshops on quality improvement in England and Wales and will be inviting teams to attend and develop ongoing QI initiatives.

National Lung Cancer Audit

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