National Lung Cancer Audit improvement toolkit

Recommendation	Suggested actions	Responsible person	Progress
1 Trusts should work to maintain or improve the quality of data submitted to the National Lung Cancer Audit (NLCA), including detailed clinical data to allow the most accurate risk adjustment to be carried out: **a both performance status (PS) and stage should be recorded in at least 90% of cases** **b the 'reason for no anticancer treatment' field of the Cancer Outcomes and Services Dataset (COSD) should be completed in 100% of relevant patients** **c for patients with stage I–II and PS 0–1, completeness for FEV1 and FEV1% should exceed 75%.**	• Appoint a clinical data lead • Use the CancerStats website to review data quality in real time • Raise the profile of performance data across the wider multidisciplinary team (MDT) at governance meetings or by sharing data • Integrate data collection into MDT meetings • Integrate clinical validation into the COSD submission process	• MDT leads • MDT members • MDT coordinators/ audit staff • Hospital managers	
2 All MDTs should appoint a 'clinical data lead' with protected time to allow promotion of data quality, governance and quality improvement (to be measured through future rounds of organisational audit).	• Agree protected time for one clinical MDT member • Support the clinical validation of data • Feedback monthly data quality reports to the wider MDT • Establish links with the local commissioner and invite them to view the trust's NLCA data • Network with other data leads to share best practice • Attend local/regional/national meetings to understand context and share best practice	• MDT leads • Hospital managers	

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3 Pathological confirmation rates below 75% should be reviewed, to determine whether best practice is being followed and whether patients have effective access to the whole range of biopsy techniques.	• 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 the pathological confirmation rate is below optimum	• MDT leads • Chest physicians • Pathologists	
4 Non-small-cell lung cancer (NSCLC), not otherwise specified (NOS) rates of more than 15% should be reviewed to ensure that best practice pathological diagnostic techniques (including immunohistochemistry) are being followed, in order that patients receive appropriate chemotherapy regimens.	• Ensure that the pathologist is an integral part of the lung MDT and understands the importance of tumour subtyping • Ensure that Royal College of Pathologists (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	• MDT leads • Chest physicians • Pathologists	
5 At least 90% of patients are seen by a lung cancer nurse specialist (LCNS); at least 80% of patients should have an LCNS present at the time of diagnosis.	• Ensure that the LCNS establishment is appropriate to the lung cancer workload • Ensure that all nursing posts are staffed • Ensure that clear referral pathways exist • Review the activities of the nursing team and reduce their administrative burden • Involve nurses in the validation of data submissions	• MDT leads • LCNS • Hospital managers • Commissioners	

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6 For patients undergoing bronchoscopy, at least 95% should have a computerised tomography (CT) scan prior to the procedure.	• Ensure that all CT/bronchoscopy data are submitted to the audit • Review patient pathways and access to investigations • Review individual clinician practices	• MDT leads • Chest physicians	
7 MDTs with lower-than-expected surgical resection rates for NSCLC (below 16% or low odds ratio after casemix adjustment) should perform a 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.	• Ensure that all surgical resections are submitted to the audit • If data are complete, review treatment policies for early stage lung cancer in patients with good PS • Review reasons for non-surgical treatment in stage I/II patients through a 'deep-dive' audit • Ensure that the thoracic surgeon attends MDT meetings	• MDT leads • Chest physicians • Thoracic surgeons • Commissioners	
8 MDTs with lower-than-expected active anticancer treatment rates (below 60% or low odds ratio after casemix adjustment) should perform a detailed case-note review to determine why patients with good PS did not receive active anticancer treatment.	• Ensure that data on all treatments are submitted to the audit • Review treatment policies for small-cell lung cancer patients; review the pathway from diagnosis to treatment to ensure that it is as expeditious as possible	• MDT leads • Chest physicians • Thoracic surgeons • Oncologists • Commissioners	

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9 MDTs with lower-than-expected chemotherapy rates for small-cell lung cancer (below 70% or low odds ratio after casemix adjustment) should perform a detailed case-note review to determine why each small-cell lung cancer patient did not receive chemotherapy.	• Ensure that data on all treatments are submitted to the audit • Review treatment policies for small-cell lung cancer patients • Subject patients who do not have chemotherapy to a 'significant event audit' to explore themes • Review the pathway from diagnosis to treatment, to ensure that patients can access treatment within 2 weeks	• MDT leads • Chest physicians • Oncologists • Commissioners	
10 MDTs with lower-than-expected chemotherapy rates for good PS (0–1) stage IIIB/IV NSCLC (below 60% or low odds ratio after casemix adjustment) should perform a detailed case-note review to determine why each advanced stage non-small-cell lung cancer patient with good PS did not receive chemotherapy.	• Ensure that all treatments are submitted to the audit • Review treatment policies for advanced stage non-small-cell lung cancer patients • Review information/messages given to patients and carers on the benefits of chemotherapy	• MDT leads • Chest physicians • Thoracic surgeons • Oncologists • Commissioners	

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

Royal College of Physicians