



NLCA 2017 outlier action plans

In 2017, the National Lung Cancer Audit (NLCA) implemented a new outlier policy for trusts that, in 4 key measures, had results that were statistically significantly worse than the overall result.

These 4 key measures are:

- Surgery in all non-small cell lung cancer (NSCLC)
- Chemotherapy in NSCLC patients (stage 3B/4 and PS 0-1)
- Chemotherapy in small cell lung cancer
- 1 year survival.

In England there were 6 trusts who were found to be statistical outliers against these key measures:

- Central Manchester University Hospitals NHS FT (RW3)
- East Kent Hospitals University NHS FT (RVV)
- Mid Essex Hospital Services NHS Trust (RQ8)
- Northampton General Hospital NHS Trust (RNS)
- Portsmouth Hospitals NHS Trust (RHU)
- Shrewsbury and Telford Hospital NHS Trust (RXW)

We asked each of these 6 trusts to create action plans that they will be implementing over the coming year to improve their results in the key measure(s). The outlier trusts had the opportunity to receive patient-level data that were used in our analysis to help inform and shape their action plans. In this document you will find these action plans. You can find out more information about the National Lung Cancer Audit including our outlier policy [here](#).

Response to the NLCA outlier report for East Kent Hospitals NHS Trust (RVV):

SCLC:

	Total number of patients with SCLC diagnosis	Number of patients treated with chemo	% treated with chemo	Adjusted % treated with chemo
NLCA dataset	53	26	49.1	42.8
Revised data after data validation	51	27	53.0	46.2

The changes in the data were due to 2 patients labelled wrongly as SCLC and one patient receiving chemo not captured in the NLCA data.

NSCLC – Stage 3/4 and PS 0-1:

	Total number of patients with NSCLC diagnosis	Number of patients treated with SACT	% treated with SACT	Adjusted % treated with SACT
NLCA dataset	116	54	46.6	45.8
Revised data after data validation	130	67	51.5	50.6

There were significant differences in the data of NSCLC stage 3/4 with PS0-1 as highlighted above. This was due to missing data and patients who had chemo within 6 months of diagnosis after radiotherapy but captured as radiotherapy only. Out of the 14 additional patients identified, 13 had SACT.

There were 7 patients from the NLCA dataset who do not have lung cancer which was identified after we went through the records of every patient on the NCLA dataset. We have attached the data for your information. Can you please rectify the records before the final report is published?

Please note [REDACTED] and [REDACTED] on the attached data (excel document) are the oncologists treating Lung cancer patients in our trust.

OUTLIER RESPONSE AND ACTION PLAN

Outline of the service

What is the population served?

500,000

Which individual organisations/hospitals make up the service?

Was Central Manchester Foundation Trust made up of Manchester Royal Infirmary and Trafford General Hospital

Who are the relevant members of the MDT?

MDTC

Lung cancer Lead

Chest Physicians –

Associate Specialist

Clinical Oncologists

Medical Oncologist

Thoracic Surgeons –

Thoracic Radiologists

LCSN-

Are there any gaps in staffing or other resources?

No medical oncologist on the MDT.

This has recently been rectified. There is no cover for annual leave but we have 2 other clinical oncologists and 1 does give chemotherapy

(Could be taken from peer review documentation)

Issue Identified

Which issue is this document addressing, and what is the context?

The chemotherapy rates for advanced NSCLC for 2016 patients were 35.6% at our trust (National mean 62.5%) This is therefore 'alarm' level of 3 SD from the mean.

How does the result compare to previous years, and to other trusts in the network/country?

The 2016 NLCA report showed a network average 59.5% and our trust 59.5%

Data Collection

What processes are in place for collecting data within and outside the MDT?

At the time we had 2 separate MDTC's across the 2 hospitals. We also had a change of MDTC mid-way through the year. They were an interim appointment who has now been replaced

What processes are in place for clinical validation prior to submission?

Not as robust as they are at present. There was some validation but only by the MDTC and not by clinical staff

Did the organisation take part in national quarterly validation?

Yes

Data Quality

Is there any evidence that local data quality falls below the national standards?

No

Is there any evidence that the local data does not match that reported by the national team?

Yes. I have reviewed the chemotherapy data by the national team. 28 potential patients did not receive chemotherapy. 18 patients were seen by oncologists and 10 did not see an oncologist. 5 of those not seen refused referral and 5 quickly deteriorated and died quickly before they could be seen.

5 extra patients received chemo but were not documented stage 3B/4 PS 0-1 therefore were not included in the data, this artificially reduced our chemotherapy rates.

Of the 28 patients 8 had the wrong PS documented (it was lower than stated in the data) [REDACTED]

If the 5 patients that received chemo were included and those 8 with incorrect PS were removed the chemotherapy rate for advanced NSCLC PS0/1 patients would be 51.2% which is slightly higher

What investigations have been carried out to determine where data submission processes have fallen short of expected?

I have personally looked through the 28 cases that did not receive chemotherapy

Is there any issue with allocation of cases to other local trusts or to other cancer teams within the trust (e.g. cancer of unknown primary)?

Not obviously

What are the barriers to improved data quality?

The lack of one MDTC across the 2 sites. This has now been rectified.

Investigation of the Issue

Has any investigation of the care given to individual patients been evaluated?

Yes. I have reviewed all the 28 cases who did not receive chemotherapy. I am happy that the majority of them did see an oncologist if they did not refuse see one. I concluded that we are not denying our patients a medical oncology opinion.

Who carried this out and was it independent?

Myself, therefore not independent.

What were the findings?

See above

Are MDT decisions followed through in the clinic/ward?

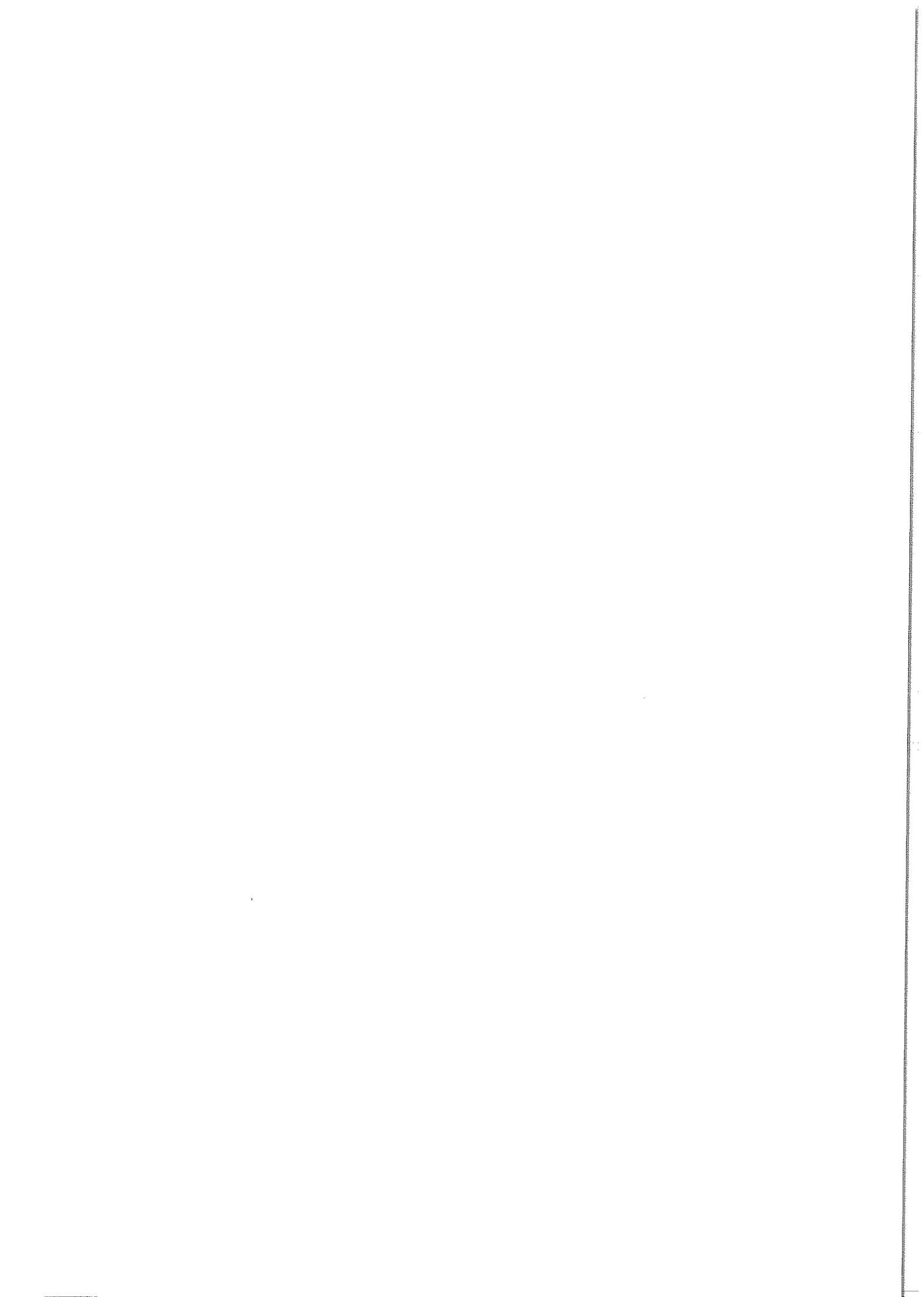
This has not been specifically looked at

Does staffing allow challenge of decisions and practice by individuals within the MDT?

There are now 3 oncologists and 2 surgeons (if full complement) so this does allow challenge

Action Plan			
Create a SMART action plan (Specific, Measurable, Achievable, Realistic, Timely)			
Action	Responsible person(s)	Timescale	Output
Lead clinician to implement monthly validation of COSD uploads	[REDACTED]	End June 2018	<ul style="list-style-type: none"> • Addition of time to job plan • Improvement in PS and stage completeness on CancerStats to 90%
Oncology team to prospectively audit reasons for good PS patients with SCLC or advanced NSCLC not receiving SACT	[REDACTED]	End December 2018	<ul style="list-style-type: none"> • Presentation of audit results at operational MDT meeting

Discussion and Dissemination	
<p>Have the national/local NLCA results been discussed within the local lung cancer team, or at the regional level?</p> <p>Not yet. This is planned</p> <p>How have/will the results of this action plan be disseminated to all interested parties?</p> <p>Yes. I will disseminate to the MDT</p>	
Name	Signature
Lung Cancer Clinical Lead:	
Medical Director: 	
Chief Executive: 	



Response to NLCA Outlier Status - Mid Essex Hospitals NHS Trust

Background

The Trust was informed of our alarm level outlier status for patients with PS0-1 and NSCLC Stage 3B and 4, with a SACT rate of 25.7% for patients treated in 2016 (national average 62.5%). Our data for 2015 patients was 70.4% (national average 63.6%). Our overall 1 year survival was within the expected average for 2016 (33.7% vs 37% national average). Our MDT is part of the Essex Lung Cancer Network and we actively participate in network level audit. Chemotherapy provision is audited annually with biennial SACT in advanced NSCLC audits. The last of these audits was 2015 patients presented at the Network audit meeting in 2016. There were no issues with the treatment at MEHT.

Service Context

The lung MDT at MEHT has struggled to be quorate due to difficulty covering our Oncology service. This has been raised as a peer review concern annually since 2014 and is on both the Medicine risk register and the Oncology risk register. In 2015 there was an experienced clinical oncologist with an interest in lung cancer treating the patients. In 2016 he was replaced by a newly appointed medical oncologist who then left in 2017.

During this time MEHT entered into negotiations with Southend Hospital as a partner Trust, as we had been unsuccessful in recruiting oncologists and at the end of 2017 the oncology medical team joined under a single leadership based at Southend. There has been a further recruitment round in 2018 and a substantive consultant has been appointed to the lung practice. In the interim the current locum consultant is supported by an experienced substantive consultant from Southend. Currently this is MDT attendance via teleconference and one on-site clinic per week but his job plan does not currently allow him to attend the MDT. It is expected the new recruitment will address this.

Data accuracy

On being informed of our outlier status we immediately performed two rapid audits. We identified and reviewed our current service looking at all the patients with stage 3B and 4 NSCLC in the time that our new Oncologist has been in post. We also looked at all the patients identified in the NLCA for 2016 and reviewed their treatment decisions.

It is clear that the NLCA has identified all the patients given treatment in 2016. It appears that the reason for the dramatic fall in SACT rate in this patient group is



largely explained by the poor data on performance status (PS) with MEHT only recording 66.5% of patients with a valid PS in the NLCA (national average 81.6%). Indeed lack of recorded PS in the audit excluded from the audit several patients who were given chemotherapy.

In the 2015 patient cohort our PS completeness was 92%. This difference is attributable to changes in data collection. In the absence of a data manager for the lung cancer patients (requested at our cancer board regularly since 2012 and highlighted in peer review since 2014) the trust lead has personally entered the data. With COSD the data entry requirement has changed from one big but short event annually to constant data checking and updating. The latter model is not sustainable with no job planned time for this and the Division of Medicine need to plan for this.

It is likely that lack of PS recording explains this outcome on the NLCA.

Our response has highlighted a significant weakness in our service provision with single handed oncology provision and lack of stability of oncology provision to the service. Our audit has not found any cases where the decision not to give SACT was clearly incorrect. It appears from our internal audits that the MDT continues to send patients to see an oncologist to consider SACT at the same rate as previously. It is not clear whether SACT was given less frequently to this group of patients in 2016 once PS data is complete.

Conclusions

The alarm level outlier status for MEHT for advanced stage NSCLC patients of good PS from 2016 given SACT in the NLCA appears to be explained by the poor completion of PS. Our internal audits have not identified any inappropriate treatment of individual patients but have highlighted service weaknesses. These weaknesses were known but have been challenging to address, particularly in response to oncology recruitment and retention.

To function optimally a lung cancer MDT in the current treatment paradigm requires a minimum of two oncologists with a sub-specialist interest in lung cancer given the rapidly changing nature of lung cancer treatment. This is likely to be best achieved through a similar model to thoracic surgery where specialist oncologists provide input to several MDTs within one region or a supra-regional MDT arrangement.



Action Plan

Issue	Action	Lead	Completion date
Sharing the review findings	Presentation of the audit with Lung Cancer MDT	MDT lead	31/3/18
Documentation of Performance Status	Ensure PS documented for all patients at MDT and data uploaded Data manager support to audit – include in business plan 2018/19	MDT lead supported by Cancer Manager MDT Lead supported by ADO Medicine & Emergency Care	31/3/18
Oncology recruitment and stability of support to team	Work with Group to provide a robust specialist oncology service for lung cancer Interim plan to cover until substantive recruitment to be shared and monitored	Oncology Manager and Clinical Lead Oncology	31/3/18

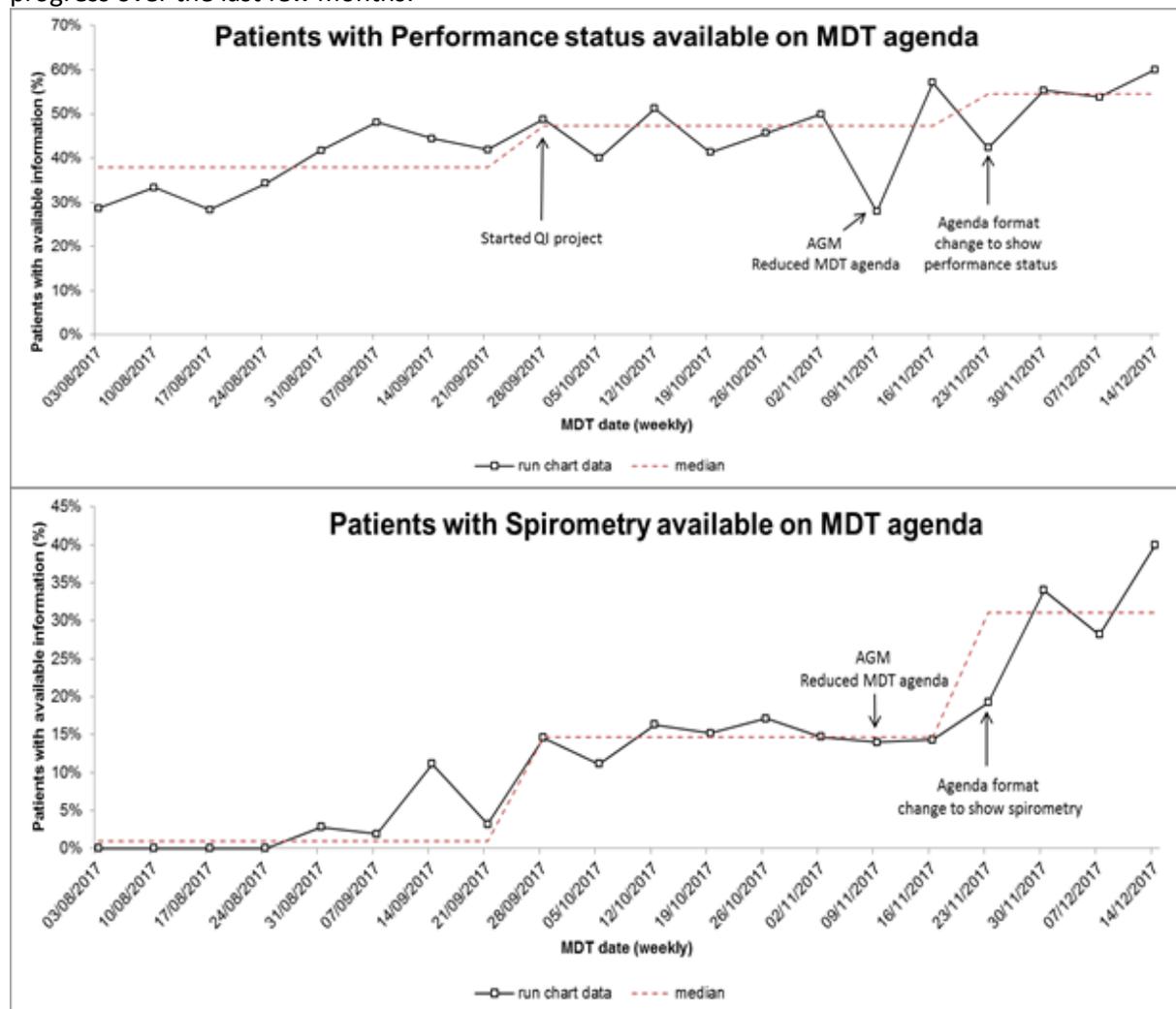
February 2018



Dear colleague,

Thank you for the opportunity to respond to the NLCA's report on 2016 activity. Northampton General has (RNS) been given an alert because the reported rate of systemic anti-cancer therapy (SACT; chemo- & immunotherapy) in patients with NSCLC was significantly lower than expected. We have been looking at why: I think there are three main components, but I need more information to be sure about the third of these.

1. MDT data: we seem to have been less good than we should have been at ensuring that key elements have been recorded by the MDT coordinator, particularly performance status, spirometry and other comorbidities. (For example, in 2016 only about 12 patients had spirometry recorded out of ~200.) Not doing so may have overestimated the number of patients who would benefit from systemic treatment. This has been the subject of a QI project this year and we have made good progress over the last few months:



We are not at the level I'd be happy with, but we're working on it. **Status: work in progress; making improvements**

2. MDT staffing: through most of 2016 and early 2017, we did not have a dedicated MDT coordinator for much of the time. The temporary ones who attended MDT did the best they could, but they did not have the familiarity with the database of a permanent coordinator. It is possible that this may have led to less data capture. **Status: solved**

3. How SACT is recorded and who does that: SACT data (chemotherapy and immunotherapy) are entered into the Chemocare system. We are unclear whether all the treatments have in fact been entered on this system and whether those data have been uploaded to NLCA. **Status: currently unresolved; needs clarification ASAP.**

Action Plan:

1. To have data on performance status (85+%), stage (95+%) and spirometry (65+%) on NLCA end of March 2018
How: ongoing lung cancer quality improvement project
2. To capture all systemic anti-cancer therapy for patients with lung cancer and ensure upload to National Lung Cancer Audit (100%) by March 2018
How: Work with Oncology department to ensure all data are recorded on Chemocare and uploaded to NLCA database.

Very happy to discuss if any of this is unclear.

With best wishes

[Redacted]

[Redacted]

OUTLIER RESPONSE AND ACTION PLAN

Outline of the service

What is the population served?

Which individual organisations/hospitals make up the service?

Who are the relevant members of the MDT?

Are there any gaps in staffing or other resources?

(Could be taken from peer review documentation)

The Lung Multidisciplinary Team (MDT) is a multi professional group serving the city of Portsmouth (Portsmouth City CCG) and its surrounding areas (Fareham and Gosport CCG, East Hants CCG). We serve a population of approximately 600,000 patients, with 200,000 living in Portsmouth city. There is a broad spectrum of socio-economic groups within the catchment area, with some of the wealthiest and poorest areas of the country. The service operates out of Queen Alexandra Hospital, an 850 bed purpose built PFI hospital. We are part of the Wessex Strategic Cancer Alliance.

The Department of Respiratory Medicine within Portsmouth Hospitals Trust (PHT) has ten consultants, four of whom deliver the lung cancer service as part of their job plan. The Respiratory Department coordinates the initial management of bronchial, pleural and mediastinal malignancies.

Portsmouth Hospital Trust (PHT) is a designated Cancer Centre, and the Oncology Department also provides services to Chichester and West Sussex. There are 2 medical oncologists and 2 clinical oncologists who attend Lung MDT and deliver treatment.

In the cases where surgical diagnostic or therapeutic procedures are required, referral is made to the Cardiothoracic Unit at Southampton General Hospital where there are 5 dedicated Thoracic Surgeons. The Respiratory Department receives about 900 urgent referrals for suspected lung cancer per year. In 2016 there were 450 confirmed cases of cancer. There were 51 cases of mesothelioma diagnosed in 2017

The MDT always has attendance by Respiratory Physicians, medical and Clinical Oncologists, Thoracic surgeons, thoracic radiologist, Lung Cancer CNSs and MDT Coordinator with secretarial admin support.

In 2016 there were 2.2 WTE CNSs, this was increased to 2.6 at the end of 2016.

Issue Identified

Which issue is this document addressing, and what is the context?

How does the result compare to previous years, and to other trusts in the network/country?

Outlier status identified for 3 areas, alarm level results for Surgery in all NSCLC (99.8% significance, alert 95%); SACT in advanced NSCLC (99.8% significance, alert 95%); alert for Chemotherapy in SCLC (95% significance, not significant for 99.8%)

Report from previous year, 2015 patient cohort showed red alert for surgery in all NSCLC and 1 year survival, and amber alert for chemotherapy in SCLC and also advanced NSCLC.

Data Collection

What processes are in place for collecting data within and outside the MDT?

What processes are in place for clinical validation prior to submission?

Did the organisation take part in national quarterly validation?

Data capture begins at first clinic visit with recording of smoking status, asbestos exposure, PS and spirometry

MDT coordinator enters data before and during MDT with electronic data capture live at MDT.

MDT Coordinator reviews missing data on a monthly basis and resubmits, this data including PS, staging and treatment provided.

MDT coordinator did receive quarterly validation and update data.

Locally participated in the spotlight audit to review surgical patients

Data Quality

Is there any evidence that local data quality falls below the national standards?

Is there any evidence that the local data does not match that reported by the national team?

What investigations have been carried out to determine where data submission processes have fallen short of expected?

Is there any issue with allocation of cases to other local trusts or to other cancer teams within the trust (e.g. cancer of unknown primary)?

What are the barriers to improved data quality?

Following data review it has been identified that there are several areas that can be used for improvement.

There is missing data for PS for a small percentage of patients and this should now be improved as the MDT Coordinator already reviews and completes this on a monthly basis. An audit of patient notes reveals that the documented PS varies from clinician to clinician and also declines over the course of the diagnostic pathway. We have re-educated the team to appropriate PS. There will be a second PS measured at the time of bad news break and re-recorded if it varies from the initial PS.

There is a need to improve number of patients reviewed by Lung CNS.

An audit of patient notes suggests that there are cases included where the patient has a primary of different origin- Upper GI and cancer of unknown primary. There is also inaccuracy of data with patients transferred from other trusts for some oncology assessment or treatment. With more robust validation process this should improve.

62 day breach shared with St Richards Hospital

PHT delivers chemotherapy and radiotherapy for patients at St Richards Hospital (Chichester). There is an increase in the PHT 62 day breach rate because we share breaches with them. They have a higher rate of late referrals than PHT thus artificially increasing our 62 day breach rate. The PHT Lung MDT has offered to help the SRH team improve their pathway by attending their MDT and meeting with their team. We participated in the RCP ILCOP project and hoped to use this learning to improve their pathway but thus far they have not accepted our offer of help. Currently, the PHT and SRH cancer management teams are meeting. The COO from PHT has recently written a letter to the executive team in SRH asking for a way forward.

We have identified a need for improved and regular working with business intelligence within the Trust to ensure regular and multidisciplinary review of the data submission and submission of missing data. We are setting up quarterly review of the data with the BI team to ensure adequate support to validate and upload data.

Investigation of the Issue

Has any investigation of the care given to individual patients been evaluated?

Who carried this out and was it independent?

What were the findings?

Are MDT decisions followed through in the clinic/ward?

Does staffing allow challenge of decisions and practice by individuals within the MDT?

Review of all patients identified to not have treatment in data sent by NLCA team by Resp Consultant and CNS.

210 identified, 16 exclusions

- 1 duplication
- 2 resolved, not cancer
- 6 had surgery
- 2 treated with SABR
- 5 received chemotherapy (3 privately)

Total 194 patients reviewed who had not received treatment and reason for this evaluated

Carcinoid- 3 patients

- [REDACTED]
- 2 patients not fit for treatment

SCLC- 21 patients

- 6 patients choice
- 11 not fit for treatment (PS 2-4)
- 4 died prior to treatment

NSCLC- 169 patients

- 42 patients choice
- 92 not fit for treatment (PS 2-4)
- 35 died prior to treatment

Surgical team review and action plan

The department of thoracic surgery in Southampton has undergone a national bench marking process; GIRFT (Get It Right First Time). It was very positive and the performance was assessed as exemplary in a number of areas. The only recommendation in thoracic is to increase lung cancer resection rate. The measure selected by the report was for patients first seen in Southampton. This potentially did not reflect true performance of a regional service. Cancer resection rate is a complex issue. All the patients with early stage lung cancer and low peri operative risks are offered surgery. We need to respect patient choice if they decline the offer of surgery. The only way to increase resection rate is to offer patients with more advanced stage disease or with limited physiological reserve.

The plan is-

- Engagement with the wider MDT to ensure high risk and complex cases not rejected for surgery without review by a surgeon in clinic.
- Establish *Complex Patient* MDT meeting attended by surgeons, anaesthetists and nursing team to plan surgery for those patients.
- Development of pre-habilitation
 - Patient with borderline respiratory / physiological reserve should have pre-operative physiotherapy and medical optimisation
 - This may have a negative impact on meeting cancer treatment targets.
- Re-establish *Enhanced Recovery Area* on our thoracic ward. This is akin to a level 1.5 area to support the post operative care of patient with borderline physiological reserve.
 - This is only achievable when we have a dedicated thoracic ward.
- Facilitate both internal and external surgical second opinions.
 - Surgeons have different skill sets and threshold for taking on high risk cases. We will facilitate internal second opinion for Borderline cases.
 - On occasion patient's clinical scenario does not fit into that described in guidelines. Surgery may be offered with the backing of the MDT.

Oncology review of SACT in Advanced NSCLC PS0-1

Total 40 patients taken from NLCA data

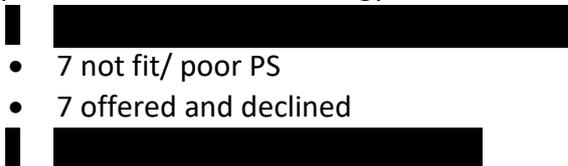
3 exclusions



22 not referred to Oncology

- 10 poor PS or not fit for biopsy
- 8 declined
- 3 diagnosed with brain mets, patient choice for no further treatment or poor PS
- [Redacted]

16 patients referred to Oncology



- 7 not fit/ poor PS
- 7 offered and declined

Oncology review of SCLC

Total 18 patients

1 exclusion

- [Redacted]

7 not referred

- 4 poor PS
- 2 patients choice

- [REDACTED]

10 referred

- 6 poor PS
- 3 offered and declined
- [REDACTED]

Review of patients with missing PS

Total 16 patients

- 5 poor PS and multiple comorbidities documented
- 11 not known to MDT so no data collection

Oncology team have also undertaken snapshot of more recent patient data



SACT in Advanced
Lung cancer patients

MDT decisions are immediately documented and fed back to clinic and inpatient wards, and followed up by Respiratory Consultant and CNS

The MDT is always open for further discussion and challenge of any decisions taken if the reviewing physician believes that this is required.

Action Plan			
Create a SMART action plan (Specific, Measurable, Achievable, Realistic, Timely)			
Action	Responsible person(s)	Timescale	Output
Lead clinician/ Respiratory Consultant, CNS and MDT coordinator to meet monthly for validation of COSD uploads	██████	Current- meetings planned in diaries	<ul style="list-style-type: none"> Improvement in PS and stage completeness on CancerStats to 90%
Oncology team to prospectively audit reasons for good PS patients with SCLC or advanced NSCLC to receiving SACT	██████	Completed for May-October 2017	<ul style="list-style-type: none"> Presentation of audit results at operational MDT meeting Future review of patients with PS0-1 for consideration of treatment
Planned monthly review of patients with PS0-1 who have not received treatment by MDT members Resp Consultant, Oncologist and CNS	██████████████████	Monthly 2018- commencing March	Prospective review of review of potential chemotherapy candidates with good PS
Quarterly Operational meeting January, April, July and October to review MDT performance an concerns	██████████████████	Commence March 2018	Regular update of MDT performance
Update MDT referral sheet to include detail required for submission and guidance to assess PS	██████	 Amended RESPIRATORY MDT R Complete	Improved MDT referrals
Improved working with business intelligence within the Trust to schedule regular data review	██████	Meeting 18/02/18- To set up regular reports monthly with required information sent to relevant members of team	Accurate data recording and submission with regular review

RCP | NLCA



<p>Missing data identified and discussed within MDT if appropriate</p>	<p>MDT coordinator</p>	<p>Monthly, commenced March 2018</p>	<p>Improve data completeness</p>
<p>Review of NOLCP Improve time to diagnosis and treatment</p>	<p>██████</p>	<p>Complete</p> <p>Meeting 13/02/18 completed paperwork and pathway commenced</p> <p>Audit of improved timescales to be undertaken to review impact on timescales</p>	<p>Introduction of 4x week new patient clinics- complete</p> <p>Allocated US biopsy slots to set up- reduce time for tissue diagnosis- complete</p>

Discussion and Dissemination

Have the national/local NLCA results been discussed within the local lung cancer team, or at the regional level?

How have/will the results of this action plan be disseminated to all interested parties?

These have been discussed locally within the MDT, and also at meetings with MSDT members- Respiratory Consultants, Oncologists, CNS team.

To be discussed at annual business meeting

Discussed at regional Wessex Network meeting

Lead Consultant sharing with Trust board

Name	Signature
Lung Cancer Clinical Lead:	
Medical Director:	
Chief Executive:	

NLCA mortality outlier report

The Shrewsbury and Telford Hospital NHS Trust has been identified in the NLCA annual audit as having an 'alarm level' outlier for one year survival (26.3% as compared with the national mean of 37%). These results have been adjusted for age, sex, stage, performance status, socio-economic status and co-morbidity.

In response to this, patient level data for 196 patients who died within twelve months of being diagnosed in 2016 were requested (out of a total of 270 new cancer diagnoses).

A case note review of these 196 patients was conducted by the lead clinician for lung cancer [REDACTED] with a selected sample of 50 patient notes undergoing a second review by a clinician from within the lung cancer MDT ([REDACTED]). The reviews included an analysis of the clinical letters, radiology, discharge summaries and Somerset cancer database entries (including MDT discussions) for each patient. The findings were presented to the trust's Chief Executive, [REDACTED] and the clinical lead for cancer services, [REDACTED].

Summary of case reviews:

Excluded patients

Total: 9

'Trust first seen' incorrectly attributed to SATH	2
No information relating to lung cancer diagnosis	3
[REDACTED]	1

Brief demographic data

Total: 187

Mean age	74
Male	103
Female	84

Route of presentation

Total: 187

Inpatient diagnosis	88
Outpatient diagnosis	98
[REDACTED]	1

Staging

Total: 187

Stage IIIb/IV non small cell lung cancer	107
Potentially curative stage non small cell lung cancer	30
Small cell lung cancer	31
Not formally staged	19

Management of patients with potentially curative lung cancer

Total: 30

Poor performance status	8
Co-morbidities/complexities precluding treatment ¹	6
Surgery	9
██	1
██	1
Concurrent malignancy impacting treatment decisions	3
Died during investigations	2
██	1

¹ All patients were judged to have had these co-morbidities appropriately assessed

Deaths following surgical resection

Total: 9

Post-surgical recurrence	3
Post-surgical complications	3
Unclear cause of death	3

Patient choice:

12 patients declined the anti-cancer treatment offered to them

Pathway and target data

Total: 187

No breach	120
62 day target not recorded on database	42
62 day target breached	19
104+ day target breached	6

Of all patients diagnosed in 2016, 73% met 62 day target (national average 72.2%, SATH annual target 85%)

Narrative

This review did not identify any significant concerns, either on an individual patient basis, or on assessing trends, that could be judged to account for the increased mortality rate.

However, the review did conclude that there is further work that needs to be done in order to address the Trust's outlier status and to ensure improvement in survival rates for patients.

Looking to the future, a number of areas have been identified where there is the potential for quality improvement work.

1. A focus on cleaner data input into the Somerset cancer database at the time of MDT meetings. This would include accurate performance status assessment, and recording of potential radiological diagnoses of lung cancer.
2. Qualitative work on performance status assessment (including standardisation of documentation)
3. Deep dive audit into those patients where potential performance status deterioration impacted on their ability to undergo anti-cancer treatment.
4. Engage with our CCGs and the West Midlands Cancer Alliance to explore ways in which the number of patients diagnosed via emergency routes can be reduced. This may include local piloting of CT screening of targeted populations.

The Trust is committed to working towards achievement of the National Optimal Lung Cancer Pathway (NOLCP) by 2020. A working group is being put together to process map the current pathway and to identify areas that would need to be adapted if the NOLCP is to be achieved. Some areas will require a change in working practice in order to achieve compliance, without the need for significant investment, whilst it is recognised that other areas will require partner support and additional resource.

The Trust has recognised the need for, and is preparing a business case to deliver, two additional lung cancer nurse specialists which would allow service specification to be met in this area. They also would enhance the Trust's potential to improve the quality of patient experience, to co-ordinate the patient journey with respect to the delivery of the NOLCP and to facilitate some pathway improvements such as nurse-led follow up clinics, nodule pathways, etc.

KEY (Change status)

- 1 Recommendation agreed but not yet actioned
- 2 Action in progress
- 3 Recommendation fully implemented
- 4 Recommendation never actioned (please state reasons)
- 5 Other (please provide supporting information)

Clinical Audit Action Plan

Audit Title	National Lung Cancer Audit
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Action plan lead	<i>Name:</i> [REDACTED]	<i>Title:</i> Consultant Lead for Lung Cancer	<i>Contact:</i>
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Recommendation	Actions required (specify "None", if none required)	Action by date	Person responsible (Name & grade)	Comments/action status (Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc)	Change stage (see Key)
1. A focus on cleaner data input into Somerset cancer database at time of MDT	Performance status assessment and potential radiological diagnoses of lung cancer to be documented during the MDT	April 2018	[REDACTED] Consultant		2
2. Qualitative work on performance status assessment	Documentation to be updated and standardised	September 2018	[REDACTED] Consultant and MDT		2
3. Further investigation into patients whose potential performance status deterioration impacted on ability to undergo anti-cancer treatment	Deep dive audit of this group of patients	September 2018	[REDACTED] Consultant [REDACTED] Clinical Audit Manager	Added to Clinical Audit Forward plan for 2018/19	1
4. Investigate ways in which patients diagnosed via emergency routes can be reduced	Meet with CCG's to discuss possibility of piloting CT screening of targeted populations locally	September 2018	[REDACTED] Consultant [REDACTED] Contracts and Performance manager		1

Recommendation	Actions required (specify "None", if none required)	Action by date	Person responsible (Name & grade)	Comments/action status (Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc)	Change stage (see Key)
5. Implementation of the National Optimal Lung Cancer Pathway (NOLDP)	Various, see below	2020			2
5a.	Set up working group to process map current pathway and identify areas that would need addressing in order to meet requirements	April 2018	██████████ Consultant ██████████ Contracts and Performance		3
5b.	Business case for two additional lung cancer nurse specialists to meet this part of requirements	June 2018	██████████ Lead Cancer Nurse		2
5c.	Set up Nurse Led Follow-Up Clinics	April 2019	██████████ Lead Cancer Nurse		1
5d.	Develop nodule pathways	April 2019	██████████ Lead Cancer Nurse Lung Cancer Nurse Specialists		1