Royal College of Physicians | National Lung Cancer Audit

National Lung Cancer Audit (NLCA) Organisational Audit 2019: Help notes

This document provides an outline of the aims and the timeline for the organisational audit, as well as specific guidance to help you answer the survey questions.

1. Introduction

The data from this audit will guide policy and recommendations on the minimum requirements that make a safe and effective lung cancer service. Participation in this audit will allow you to highlight areas of good practice and identify issues with access to resources and staffing that may have an impact on local patient outcomes.

The first NLCA organisational audit was performed in 2014 and the second in 2017 – each has demonstrated significant variation in service provision and workload of lung cancer specialists. The following recommendations were made in 2017:

1. All patients should have local access to smoking cessation and pulmonary rehabilitation services.
2. All core MDT members should have dedicated time to attend a weekly MDT meeting, discussing no more than 30 patients in 2 hours.
3. All MDTs should ensure adequate specialist time commitment, as specified in the national commissioning guidance.
4. All providers without a separate diagnostic MDT or triage process should implement this within the next 12 months as specified in the new commissioning guidance (https://bit.ly/2U7cFp4).

2. Aims

Building on the previous audit, the NLCA's 2019 organisational audit aims to:

1. Provide information for benchmarking best practice nationally
2. Highlight differences in the provision of lung cancer diagnostic services, treatment modalities and lung cancer specialists
3. To measure the extent to which the recommendations made in 2017 have been met
4. To investigate the relationship with clinical outcomes.

3. The 2019 audit tool

The organisational audit data will be collected via an online survey made available by the NLCA team during the data collection period.

4. Survey completion period: 08 May-19 June 2019

Sites that have registered must complete and submit the survey by 19 June. A checking week will take place between 20 and 26 June; we may contact sites during this time for clarification on the data provided. After this time it will not be possible to change any answers.

5. Auditors

The survey should be completed by a member of the lung cancer team that has access to the relevant information. This would usually be a clinical manager or a senior member of the clinical team. **The information provided should reflect the current organisation of the service, and not any changes to the service that are planned or even imminent.** In order to ensure consistency of results the person/s completing the survey must have access to these help notes. Each site will have a designated lead clinician who will have overall responsibility with the audit department for the data quality from their trust/health board.

6. Data analysis and reporting

Data analysis will be carried out in July by the NLCA team. The data from the survey will be linked to the 2017 NLCA clinical data to put the results in context. A trust-level summary report will be made publicly available on our website (unless you request otherwise), and a copy will be sent directly to the trust clinical lead. A final report of all the results will be published by the end of 2019.

7. For further information/queries

Please send queries to the NLCA team at NLCA@rcplondon.ac.uk. If you would like to speak directly to a member of the team, please email the NLCA team and we will arrange a suitable time to call you back.

8. Guidance on completing the survey

No.	Data Item	Data Definition	Responses	Audit Help Notes
BASIC INFORMATION				
1	Name of your Trust/Health board	**Hospital**: An organisation providing secondary healthcare services in England/Wales. A hospital trust may be made up of one or several hospitals within a region. **If you are in England**: we will be asking about services that relate to your specific trust. **If you are in Wales**: we will be asking about services that relate to your specific hospital.	Prefilled	If your trust has more than one hospital that are providing separate lung cancer services such that you cannot complete the survey for the whole trust, please email (NLCA@rcplondon.ac.uk) us to discuss.
2	Code of your trust/health board		Prefilled	Your 3-digit organisation code is as listed in the NLCA annual report.
3	Please provide us with the following details about the lung cancer lead	**Lung cancer lead**: The professional in your hospital taking overall responsibility for the services provided to lung cancer patients. This person will have overall responsibility with the audit department for the data quality from your hospital. This person will 'sign off' the responses to this audit.	3a Name 3b Email 3c Telephone	We need this in case we need to check/clarify your answers. This will normally be the person to whom we have sent the link. If this is not the case, please email (NLCA@rcplondon.ac.uk) to let us know.
MULTI-DISCIPLINARY MEETINGS				

4	Do you routinely hold separate diagnostic and treatment MDT meetings?	**MDT**: 'multidisciplinary team' - a group of healthcare professionals working in a coordinated manner for patient care. **Diagnostic MDT Meeting**: Meeting where the patients' diagnostic work-up is planned. Non-cancer cases may be discussed at this meeting. Typically attended by an MDT co-ordinator or specialist nurse, chest physician and thoracic radiologist. **Treatment MDT Meeting**: Meeting where the patients' management is discussed, which may include the diagnostic work-up. Only patients with suspected or confirmed lung cancer are discussed at this meeting. Should have the following core members in attendance throughout the meeting: MDT co-ordinator, lung cancer physician, thoracic radiologist, thoracic pathologist, lung cancer clinical nurse specialist, lung cancer medical oncologist (systemic therapy), lung cancer clinical oncologist (radiotherapy), a thoracic surgeon, and a palliative/supportive care specialist.	Yes No	From now onwards the 'Treatment MDT' will be referred to as the 'Full MDT'.
5	How often are your diagnostic MDT meetings?	See above for definition.	Not applicable Daily Two per week Three per week Four per week Weekly Fortnightly	
6	What is the time allocated for your diagnostic MDT meeting/s?	See above for definition.	Not applicable <=1 hr 1 - 1½ hrs 1½ - 2 hrs	If you have more than one MDT per week, please state the total time allocated in a week.

			2 - 2½ hrs 2½ - 3 hrs 3 - 3½ hrs 3½ - 4 hrs	
7	How often are your full MDT meetings?	See above for definition	Daily Two per week Three per week Four per week Weekly Fortnightly	
8	What is the time allocated for your full MDT meeting/s?	See above for definition	<=1 hr 1 - 1½ hrs 1½ - 2 hrs 2 - 2½ hrs 2½ - 3 hrs 3 - 3½ hrs 3½ - 4 hrs	If you have more than one MDT per week, please state the total time allocated in a week.
9	On average, how many patients are discussed at your full MDT meeting/s per week?	The number should reflect the average number of cases per week discussed at your full MDT in Q1-2 2019.	Number of patients	We would suggest asking your MDT co-ordinator to look through the minutes of the last 5 meetings to work out the average number. If you have more than one full MDT per week, please state the average number of patients discussed in a week during these meetings.
10	Do the following routinely attend the whole of the full MDT meeting, or do they only attend for cases "relevant" to their specialty? 10a Thoracic surgeon 10b Pathologist	We want to know whether the meeting is structured so that certain specialists can drop in for cases relevant to them.	Does not attend meeting Attends for whole of meeting Attends only for relevant cases	

	10c Medical oncologist 10d Clinical oncologist 10e Palliative care			

STAFFING

We understand that working practices are complex and it can sometimes be difficult to calculate how much of a person's job is dedicated to lung cancer, but please do your best to answer the following questions accurately. These questions refer to staff **directly involved in the management of lung cancer patients** at your hospital in June 2019.

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Staff group	Number	Filled WTEs	Number of PAs of direct clinical care for lung cancer
Chest physicians			

Chest physicians: these will be chest physicians routinely doing out-patient clinics for new and follow-up patients. Include out-patient clinics, MDT working, EBUS….**but not standard bronchoscopy**

*Example: we have 8 chest physicians but although all do bronchoscopy, only **4** are directly involved in lung cancer care. These 4 consultants have job plans for 12PAs (=1 WTE), 11 PAs (=1 WTE), 10 PAs (=1 WTE), and 7 PAs (=0.7 WTE) – so we have **3.7 WTEs**. Within these job plans, there are overall **10 PAs** covering clinics, MDT working, EBUS lists and other sessions of direct clinical care of lung cancer patients.*

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Staff group	Band 5 WTEs	Band 6 WTEs	Band 7 WTEs	Band 8 WTEs
Lung cancer nurse specialist				

A whole-time equivalent (WTE) can easily be calculated on the basis that 37.5 hours/week is one WTE.

<table>
<tr><td>13</td><td colspan="3"><table><tr><th>Staff group</th><th>Number</th><th>Filled WTEs</th><th>Number of oncologists who have at least one third of their clinical time devoted to lung cancer.</th></tr><tr><td>Clinical oncologists</td><td></td><td></td><td></td></tr><tr><td>Medical oncologists</td><td></td><td></td><td></td></tr></table></td><td>Oncologists may treat more than one type of cancer. Estimate what proportion of the workload is related to lung cancer.

Example: we have 2 oncologists that see lung cancer patients. One is full time (10+ PAs), and the other is half-time (0.6 PAs), so we have 1.6 WTEs. One oncologist covers multiple tumour types and does not give 1/3 of their time to lung cancer, so we have 1 oncologist who has at least one third of their clinical time to lung cancer.</td></tr>
<tr><td>14</td><td colspan="3"><table><tr><th>Staff group</th><th>Number</th><th>Filled WTEs</th><th>Number of radiologists who have at least one third of their clinical time devoted to lung cancer.</th></tr><tr><td>Thoracic radiologists</td><td></td><td></td><td></td></tr></table></td><td>Radiologists may specialise in more than one area, and also carry out generic work. Estimate what proportion of the workload is related to lung cancer.</td></tr>
<tr><td>15</td><td>Number of histopathologists in your organisation.</td><td></td><td></td><td></td></tr>
<tr><td>16</td><td>Number of histopathologists who routinely report on lung cancer specimens.</td><td></td><td></td><td></td></tr>
<tr><td>17</td><td>Does your lead clinician have dedicated time in their job plan for this role?</td><td></td><td>Yes, <0.5 PA
Yes, 0.5-1.0 PA
Yes, >1.0 PA
No</td><td></td></tr>
<tr><td>18</td><td>Do you have a clinical member of the MDT with responsibility for data</td><td></td><td>No
Yes, but no dedicated time</td><td></td></tr>
</table>

	quality, and do they have dedicated time in their job plan for this		Yes, with dedicated time	
19	Do you have a mechanism to clinically validate COSD submissions before upload?		Yes No	
20	Do you have access to the CancerStats website, and do you use it to monitor data quality?		No Yes and access rarely Yes and access regularly	
21	Do you currently have any unfilled posts?		Free text	Please list the type and number of unfilled posts
DIAGNOSTIC AND STAGING SERVICES				
This question refers to treatments available to your lung cancer patients at your trust in June 2019. Only select "Yes" if the pathway if established and routine.				
22	Do your GPs use any form of risk assessment tool as part of their referral decision-making?		Yes No Don't know	Examples of risk assessment tools would include Q-cancer, or eCDS (based on CR-UK risk assessment tool).
23	Do you have a routine "straight to CT" pathway for patients with an abnormal CXR?	"Straight to CT" means that an abnormal CXR suggesting lung cancer directly triggers a CT scan without the need for a separate referral from primary care.	Yes No	
23a	If Yes, then what is the turnaround time for this?		Number of days	
24	Do you have a routine pathway to triage referrals to the lung cancer service on the	This triage is done before the patient is seen by a chest physician, and streams patients into the lung cancer clinic, another type of outpatient or virtual clinic, or discharges the patient back to their GP.	Yes No	

	basis of a CT scan result?			
25	How frequently does this triage process occur?		Daily Two per week Three per week Four per week Weekly Fortnightly	
26	Who carries out the triage process?		Consultant chest physician Specialist nurse Consultant radiologist Specialist registrar Other	
27	Is there a mechanism within the radiology department to flag abnormal imaging suggesting lung cancer to the lung cancer team?		Yes No	
28	Have you implemented a curative treatment pathway to organise a bundle of investigations at the first clinic visit?	As defined in the National Lung Cancer Optimal Pathway (https://bit.ly/2urVAYy)	Yes No	
29	Is there a pathway for management of patients with pulmonary nodules?		Yes No	

30 Please provide the following information relating to diagnostic and staging modalities available to your lung cancer patients:

Test	On site/off-site/unavailable	Typical time to test (days)	Typical time to result (days)
Bronchoscopy			
EBUS			
Local anaesthetic thoracoscopy			
Video assisted thoracoscopy			
CT-PET			
Radiological biopsy			
Spirometry			
Gas transfer			
Echocardiography			
Cardiopulmonary exercise testing			
EGFR mutation testing			
ALK translocation testing			
ROS1 testing			
PDL1 testing			

On site: This service is provided for your lung cancer patients at your trust/health board.

Off site: Access to this service is provided for your lung cancer patients via an established referral pathway to another trust/health board.

Not available: There is not a provision for access to this service for your lung cancer patients at your trust/health board or via an established referral pathway.

31	Do you meet the 3 day pathological subtype standard in the majority of your lung cancer biopsy specimens?	Yes No	We suggest asking your pathology department to calculate the turnaround times (working days) for the last 10 cases of lung cancer, and answer "Yes" if you achieved the standard in >75% of cases
32	Do you meet the 10 day molecular marker standard in the majority of your lung cancer biopsy specimens?	Yes No	We suggest asking your pathology department to calculate the turnaround times (working days) for the last 10 cases of lung cancer, and answer "Yes" if you achieved the standard in >75% of cases

LUNG CANCER TREATMENT

<table>
<tr>
<td>33</td>
<td colspan="3">Please provide us with the following information relating to treatment modalities available to your lung cancer patients in June 2019.
<table>
<tr><th>Test</th><th>On site/off-site/unavailable</th><th>Typical time from referral to treatment (days)</th></tr>
<tr><td>Biological therapy e.g. TKIs</td><td></td><td></td></tr>
<tr><td>Immunotherapy</td><td></td><td></td></tr>
<tr><td>Stereotactic radiotherapy to lung primary</td><td></td><td></td></tr>
<tr><td>Stereotactic radiotherapy to cerebral metastases</td><td></td><td></td></tr>
<tr><td>Thoracic surgery</td><td></td><td></td></tr>
<tr><td>VAT lobectomy</td><td></td><td></td></tr>
<tr><td>Dietician</td><td></td><td></td></tr>
<tr><td>Palliative / supportive care</td><td></td><td></td></tr>
</table>
</td>
<td>On site: This treatment is provided for your lung cancer patients at your trust/health board.

Off site: Access to this treatment is provided for your lung cancer patients via an established referral pathway to another trust/health board.

Not available: There is not a provision for access to this treatment for your lung cancer patients at your trust/health board or via an established referral pathway.</td>
</tr>
<tr><td>34</td><td>Do you have an agreed policy for recording smoking status in patients being assessed though the lung cancer pathway?</td><td></td><td>Yes
No</td><td></td></tr>
<tr><td>35</td><td>Do you have an agreed policy for treating tobacco addiction in patients being assessed though the lung cancer pathway?</td><td></td><td>Yes
No</td><td></td></tr>
<tr><td>36</td><td>Do you prescribe pharmacological treatment for tobacco addiction from within your lung cancer service?</td><td></td><td>Yes
No</td><td></td></tr>
<tr><td>37</td><td>How many of the respiratory physicians identified in Q11 have</td><td></td><td>Number</td><td></td></tr>
</table>

	received formal training in smoking cessation "very brief advice"?			
38	Do you have a pulmonary rehabilitation service suitable for patients on the lung cancer pathway?		Yes No	
39	Do you run a multi-disciplinary lung cancer MDT clinic?	Typically, this would mean a clinic taking place on the same day as the full MDT, where patients can see a chest physician, thoracic surgeon, clinical oncologist or medical oncologist as needed.	Yes No	
FOR TRUSTS PROVDING THORACIC SURGERY ON SITE				
40	Do you have thoracic surgery on-site?		Yes No	If no, move on to Q47
41	Number of thoracic surgeons working in the lung cancer service.			
42	How many thoracic surgeons with at least one third of their clinical time dedicated to lung cancer work in your unit?			
43	Does your unit have at least 3 full-time general thoracic surgeons?		Yes No	
44	How many thoracic surgery theatre sessions are there per week?			
45	How many high dependency beds do you have that are dedicated			

	for thoracic surgery patients?			
46	Do you experience problems with flow of lung cancer patients though the surgical service as a result of inadequate HDU beds?		Never Rarely Sometimes Frequently	
ADDITIONAL QUESTIONS				
47	What are the main bottlenecks in your diagnostic/treatment pathway?		Free text	
48	Please use this space to provide any additional comments you may have?			
49	Are you happy for a summary of your results to be publicly available from our website?		Yes No	