



National Lung Cancer Audit outlier policy for Wales 2018

The National Lung Cancer Audit (NLCA) publishes detailed information on the treatment of lung cancer patients, including the outcome of that treatment.

Data for the NLCA is based on patient-level information collected by the NHS, as part of the care and support of cancer patients. The data for Wales are collated and quality assured by the Wales Cancer Network (WCN). The data for England is collated, maintained and quality assured by the National Cancer Registration and Analysis Service (NCRAS) at Public Health England; a separate but comparable process for Welsh hospitals has been produced.

This policy outlines the steps to:

- identify poor performance in the NLCA
- provide standardised feedback to and communication with provider organisations

This is in accordance with the Healthcare Quality Improvement Partnership's *Detection and management of outliers for National Clinical Audits*¹.

Data quality

In Wales data are submitted to the audit annually by the Wales Cancer Network (WCN) on behalf of Health Boards using the data collected via the CANISC system as part of the management of patients. Data quality reports are provided quarterly to MDTs and we encourage regular clinical validation of the data to minimise any issues further downstream. Quality checks on the data are undertaken by the Wales Cancer Network and any anomalies and missing data brought to the attention of the MDTs for them to correct. The final validation of Welsh data is clinically signed off by the MDT lead prior to submission. Historically, the completeness of the data for Wales has been excellent. Completeness for Performance Status and stage is reported alongside other measures.

¹ <https://www.hqip.org.uk/wp-content/uploads/2018/10/Provider-operationalisation-of-national-outlier-guidance-for-Wales-Nov.pdf>



Identifying poor performance

Benchmarking in the NLCA is based on headline indicators which are important measures of the overall quality of care. These indicators are reviewed and set annually by the NLCA team with the guidance of additional clinical experts that make up the NLCA Clinical Reference Group².

Data submitted to the NLCA are analysed by a team at the University of Nottingham with appropriate statistical expertise and experience.

Raw proportions are used to benchmark against a median value or value based on clinical opinion within the project team.

For some indicators, statistical analysis of these proportions are 'case-mix adjusted' for clinical features, including age, sex, performance status, socio-economic status and cancer stage. This allows the identification of statistical outliers.

For the 2018 (2017 cohort) NLCA, outlier status will be determined for the following case-mix adjusted indicators which reflect a range of processes and outcomes and are considered robust:

- 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
- Pathological confirmation rate in stage I/II and PS 0-1 patients

For the lung cancer clinical outcome publication 2018 (2016 cohort), outlier status will be determined for the following case-mix adjusted indicators:

- Unit-level 30 day survival
- Unit-level 90 day survival
- Unit-level one year survival

Methodology for identifying outliers

The analysis uses a multivariate logistic regression model to determine the probability that a result is significantly different from the national mean. The following variables are used in the model: age at diagnosis, gender, pre-treatment disease stage, performance status and socio-economic status.

² <http://www.rcplondon.ac.uk/projects/outputs/data-collection-and-indicators>



Following analysis two levels of significance are determined – an “alert” level of 2 standard deviations from the mean, and an “alarm” level of 3 standard deviations from the mean. These correspond to significance levels of 95% and 99.8% respectively. We have refined the analysis to allow us to report a case-mix adjusted percentage, rather than an odds ratio, a number that is more meaningful both to clinicians and the public. These results are graphically illustrated using funnel plots.

The process for analysing the data will be double-checked and signed off by the senior analyst at the University of Nottingham and senior NLCA clinical lead.

Process – Annual Report 2018 (see Appendix 4)

Date	Action	Responsibility
5 October 2018	MDTs to sign off validation and verification of patient level data	Lung cancer teams
19 November 2018	Patient level data submitted for the audit	WCN
10 December 2018	UoN send patient level data to WCN and once received WCN will prepare the data for dissemination	AK, WCN
10 December 2018	All participating organisations will be sent summary data to their lung cancer clinical lead. This will include raw proportions, casemix-adjusted proportions, and for the 5 measures listed above an indication of outlier status. The summary will be accompanied by a copy of this outlier policy.	NLCA
10 December 2018	Patient level data available for health boards in Wales to request via the WCN.	WCN
4 January 2019	Deadline for alarm and alert level outliers to provide initial respond to NLCA (copied to the WCN).	Lung cancer teams
14 January 2019	Formal outlier letters sent to CEOs and MDs. Organisations will be sign-posted to the NLCA improvement toolkit as a resource for service improvement advice. Response and action plans expected within 60 working days.	NLCA
14 January 2019 to April 2019	NLCA annual report signed off.	NLCA
April 2019	Launch of NLCA annual report with details of alarm-level outliers. An online spreadsheet will also be published containing more detailed data as well as identification of the alert, alarm and positive outliers.	NLCA/HQIP
June 2019	A further appendix will be made available on-line with the responses and action plans of those with “alarm” status.	NLCA



Process – LCCOP

For the lung cancer clinical outcome publication 2018, the outlier policy will be managed by the Society for Cardiothoracic Surgery. The policy is available on the following website:

https://scts.org/userfiles/pages/file/Audit%20and%20Outcomes/SCTS_thoracic_outlier_advice_approved%20exec%2009-10-15.pdf

For more information please contact the NLCA team at NLCA@rcplondon.ac.uk



Appendix 1: Initial Summary Data Letter to Trusts

NLCA Annual Report Summary Data



Derby Hospitals NHS FT (RTG)

East Midlands Strategic Clinical Network

Clinical Lead: Paul Beckett

This brief report details the provisional results for patients diagnosed with lung cancer and first seen at your trust in 2016. Further details of the NLCA/NCRAS "trust first seen" algorithm is available on our website. The report includes details of your outlier status on our key measures and should be noted in conjunction with our outlier policy. This data will be put into the public domain in late January 2018 via the NLCA Annual Report.

You have been identified as an "alarm" outlier on one or more of the key measures. You are invited to provide an initial response to the NLCA within by the end of 22nd December 2017.

Data Completeness

Metric	Result	National mean
Number of Cases	400	-
Performance Status	85.0%	83.0%
Stage	95.0%	92.0%

Process

Metric	Result	Adjusted result ¹	National mean
Pathological Confirmation	74.0%	73.0%	80.0%
NOS Rate	6.0%	12.0%	15.0%
PET before radical	99.0%	98.0%	90.0%
LCNS Assessed	88.0%	70.0%	75.0%
LCNS Diagnosis	75.0%	62.0%	80.0%

Outcome

Metric	Result	Adjusted result ¹	National mean	95% significance ²	99.8% significance ³
Surgery in all NSCLC	21.0%	32.0%	23.0%	Not significant	Not significant
Chemotherapy in NSCLC	82.0%	45.0%	56.0%	Not significant	Not significant
Chemotherapy in SCLC	84.0%	63.0%	77.0%	Good practice	Not significant
One Year Survival	25.0%	22.0%	38.0%	Alert	Alarm

Data for this report is based on patient-level information collected by the NHS, as part of the care and support of cancer patients. The data is collated, maintained and quality assured by the National Cancer Registration and Analysis Service, which is part of Public Health England (PHE). Validation of local data has been performed in collaboration with local lung cancer teams.

¹Adjusted for age, sex, stage, performance status, socio-economic status and co-morbidity :: ²Less than 5 in 100 chance that the results are due to chance :: ³Less than 2 in 1000 chance that the results are due to chance



Appendix 2: Draft letter to "Alarm" Hospital

NLCA Outlier Letter

Derby Hospitals NHS FT RTG

East Midlands Strategic Clinical Network



For the attention of lung cancer clinical lead (Paul Beckett):

I am writing as the Senior Clinical Lead for the National Lung Cancer Audit at the Royal College of Physicians.

We are about to publish the results of the analysis of data on patients who were diagnosed in 2016. The purpose of this letter is to give you advance warning that your organisation has been identified as having results in one or more key areas that lies outside three standard deviations of the predicted rate ("alarm level"). We are required to put these data in to the public domain.

We have adjusted the data for case-mix, and full details are included in our outlier policy which we have included with this correspondence (https://www.rcplondon.ac.uk/projects/national-lung-cancer-audit). Briefly this model takes account of the age, gender, socioeconomic status, disease stage and performance status of the patient cohort. Following analysis two levels of significance are determined – an "alert" level of 2 standard deviations from the mean, and an "alarm" level of 3 standard deviations from the mean. These correspond to significance levels of 95% and 99.8% respectively. We have refined the analysis to allow us to report a case-mix adjusted percentage, rather than an odds ratio, a number that is more meaningful both to clinicians and the public. We have also highlighted "Good practice" where results are a statistical outlier but in a positive direction.

There are a number of possible reasons why your data may show you as an outlier. It may be that it is a real observation in which case we would be happy to help review your service and get in place a plan to improve outcomes. It may be that there is a data quality issue which has not been picked up in earlier validation. Alternatively it could be that there is some case-mix variable that we have not included in the model that is having a major impact in your population that is not present elsewhere in the country.

We would ask you to look at the data below and provide an initial response to us by the end of 22nd December 2017. We anticipate that you will want to review the patient level data that has been used to carry out our analysis, and we will be contacting you separately to make arrangements to share this data with you. Details of trusts performing outside "Alarm" limits will be included in the NLCA Annual report which will be published on 24th January 2018. We will include the details of your initial response in the report.

We will be sending formal outlier letters to trust medical directors and CEOs with "Alarm" level results on 4th January 2018. This letter will invite you to provide your formal response and action plan within 60 days of receipt. This formal response will be included in the online appendix to the Annual Report to be published on 29th March 2018.

We would be happy at the RCP to discuss the data in more detail with you if there is anything that is not clear. We would also be happy to help put together a plan for service improvement if it does look as if there are issues that need to be addressed.

Handwritten signature of Paul Beckett

Dr Paul Beckett

Consultant Respiratory Physician, Senior Clinical Lead NLCA

Metric	Result	Adjusted result	National mean	95% significance ¹	99.8% significance ²
Surgery in all NSCLC	21.0%	32.0%	23.0%	Not significant	Not significant
Chemotherapy in advanced NSCLC	82.0%	45.0%	56.0%	Not significant	Not significant
Chemotherapy in SCLC	84.0%	63.0%	77.0%	Good practice	Not significant
1 year survival	25.0%	22.0%	38.0%	Alert	Alarm

Data for this report is based on patient-level information collected by the NHS, as part of the care and support of cancer patients. The data is collated, maintained and quality assured by the National Cancer Registration and Analysis Service, which is part of Public Health England (PHE). Validation of local data has been performed in collaboration with local lung cancer teams. The results have been adjusted to take into account the patient casemix. Variables considered are age, gender, laterality, performance status, disease stage, socio-economic status and comorbidity.

¹ Less than 5 in 100 chance that the results are due to chance ; ² Less than 2 in 1000 chance that the results are due to chance



Appendix 3: Draft letter to "Alert" Hospital

NLCA Outlier Letter

Derby Hospitals NHS FT RTG

East Midlands Strategic Clinical Network



For the attention of lung cancer clinical lead (Paul Beckett):

I am writing as the Senior Clinical Lead for the National Lung Cancer Audit at the Royal College of Physicians.

We are about to publish the results of the analysis of data on patients who were diagnosed in 2016. The purpose of this letter is to give you advance warning that your organisation has been identified as having results in one or more key areas that lies outside two standard deviations of the predicted rate ("alert level"). We are required to put these data in to the public domain.

We have adjusted the data for case-mix, and full details are included in our outlier policy which we have included with this correspondence (https://www.rcplondon.ac.uk/projects/national-lung-cancer-audit). Briefly this model takes account of the age, gender, socioeconomic status, disease stage and performance status of the patient cohort. Following analysis two levels of significance are determined – an "alert" level of 2 standard deviations from the mean, and an "alarm" level of 3 standard deviations from the mean. These correspond to significance levels of 95% and 99.8% respectively. We have refined the analysis to allow us to report a case-mix adjusted percentage, rather than an odds ratio, a number that is more meaningful both to clinicians and the public. We have also highlighted "Good practice" where results are a statistical outlier but in a positive direction.

There are a number of possible reasons why your data may show you as an outlier. It may be that it is a real observation in which case we would be happy to help review your service and get in place a plan to improve outcomes. It may be that there is a data quality issue which has not been picked up in earlier validation. Alternatively it could be that there is some case-mix variable that we have not included in the model that is having a major impact in your population that is not present elsewhere in the country.

We would ask you to look at the data below, but we do not need a formal response from you and we will not be sending a formal outlier letter to your trust medical director and CEO. We anticipate that you will want to review the patient level data that has been used to carry out our analysis, and we will be contacting you separately to make arrangements to share this data with you. Details of "alert" level outliers will not be included in our Annual Report which will be published on 24th January 2018, but will be included in an online spreadsheet at the same time.

We would be happy at the RCP to discuss the data in more detail with you if there is anything that is not clear. We would also be happy to help put together a plan for service improvement if it does look as if there are issues that need to be addressed.

Dr Paul Beckett

Consultant Respiratory Physician, Senior Clinical Lead NLCA

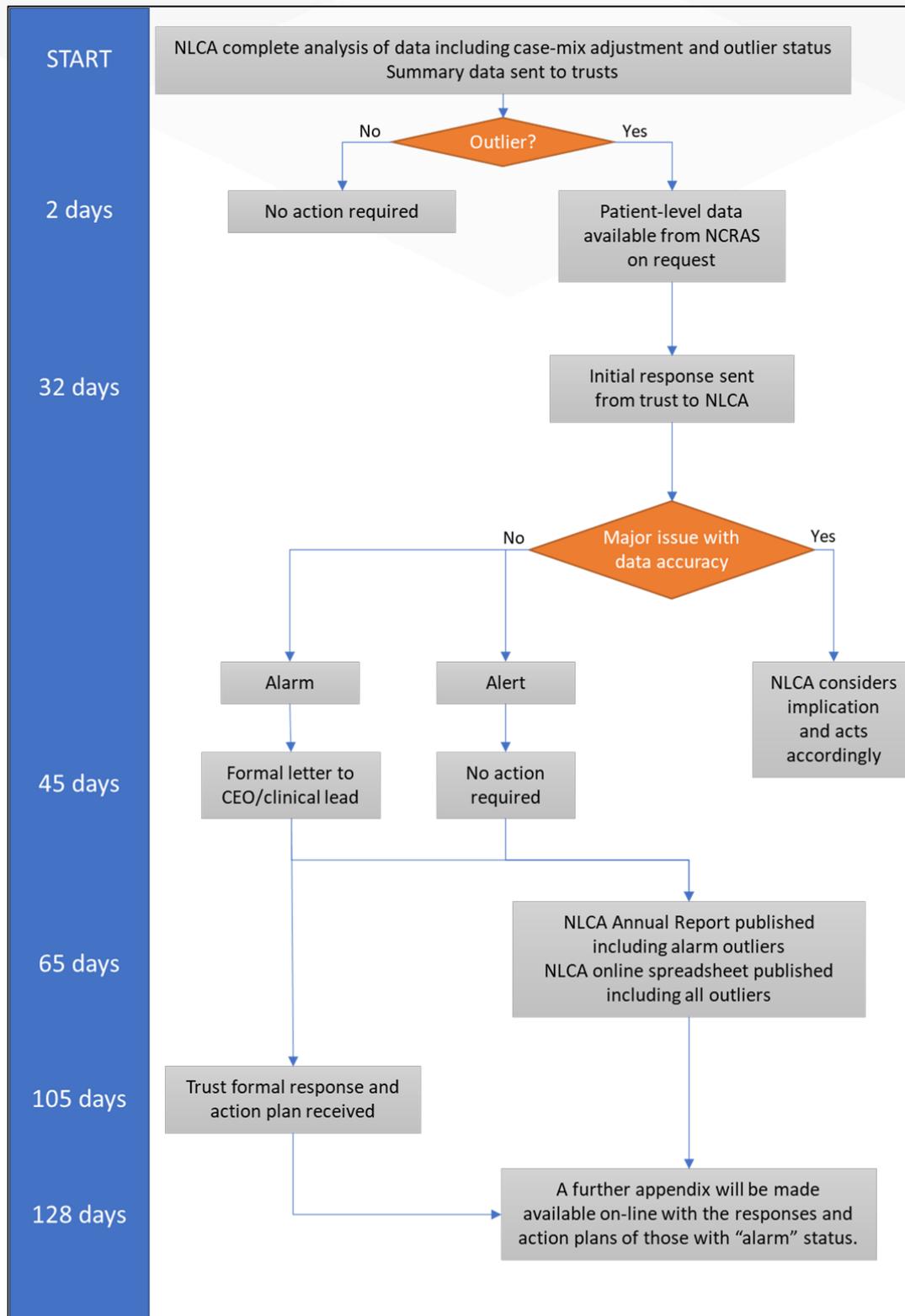
Metric	Result	Adjusted result	National mean	95% significance ¹	99.8% significance ²
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Data for this report is based on patient-level information collected by the NHS, as part of the care and support of cancer patients. The data is collated, maintained and quality assured by the National Cancer Registration and Analysis Service, which is part of Public Health England (PHE). Validation of local data has been performed in collaboration with local lung cancer teams. The results have been adjusted to take into account the patient casemix. Variables considered are age, gender, performance status, disease stage, socio-economic status and co-morbidity.

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Appendix 4: Flowchart of Outlier Process





Appendix 5: Frequently Asked Questions

It is important to highlight to providers that they are an outlier but it will cause angst and pressure especially when the CEO gets the letter. It is definitely a good idea to give the advance warning message to the clinical lead first?

We understand that it will not be a letter clinical leads will want to receive, however if the audit is to continue we have to be more effective in changing practice. The NLCA team will respond to any queries and will need to make sure all appropriate steps have been taken before publication.

For surgery rates in NSCLC, will a provider only be considered an outlier if the rates are low in the 'good performance status' group? Why is performance status (PS) mentioned in the indicator for chemotherapy in advanced NSCLC patient group but not in the surgery rates?

Chemotherapy is only recommended by NICE for stage 3b/4 patients with good PS hence restricting the patient group. For surgery we include all patients and the data are case-mix adjusted.

If MDTs in Wales request patient level data on 22 November how long will it take to come to MDTs?

Colleagues at NCRAS will have the data available from 22 November and it will be sent securely, and as soon as possible that week, to the clinical leads or a nominated member of their team.

If a provider is an alert or alarm level outlier, what level of detail do you require as an initial response if they are not able to alter the data?

This will be up to the provider. An example might be that due to major issues with data submissions the provider believes that the results are not valid. The NLCA team will then decide how best to use this information.

As there are methodological differences in measuring deprivation levels in England and Wales, will this hinder the comparisons?

In the NLCA analysis the Townsend Index method of measuring deprivation is used for both Wales and England. In all the studies that we have published, the association of socio economic status is present in the outcomes but it is not as influential as PS and stage.