

NICE Quality Standards and COF

David Baldwin

Consultant Respiratory Physician NUH

Hon Senior Lecturer Nottingham University

Clinical lead NICE lung cancer GL

Chair NICE QS Topic Expert Group

Quality Standards

<http://guidance.nice.org.uk/qualitystandards/qualitystandards.jsp>

- **Based largely on NICE GL**
- **Supposed to be aspirational**
- **Need to be easily measurable**
- **Limited to 15**

Quality Statements, Measures and Outcomes

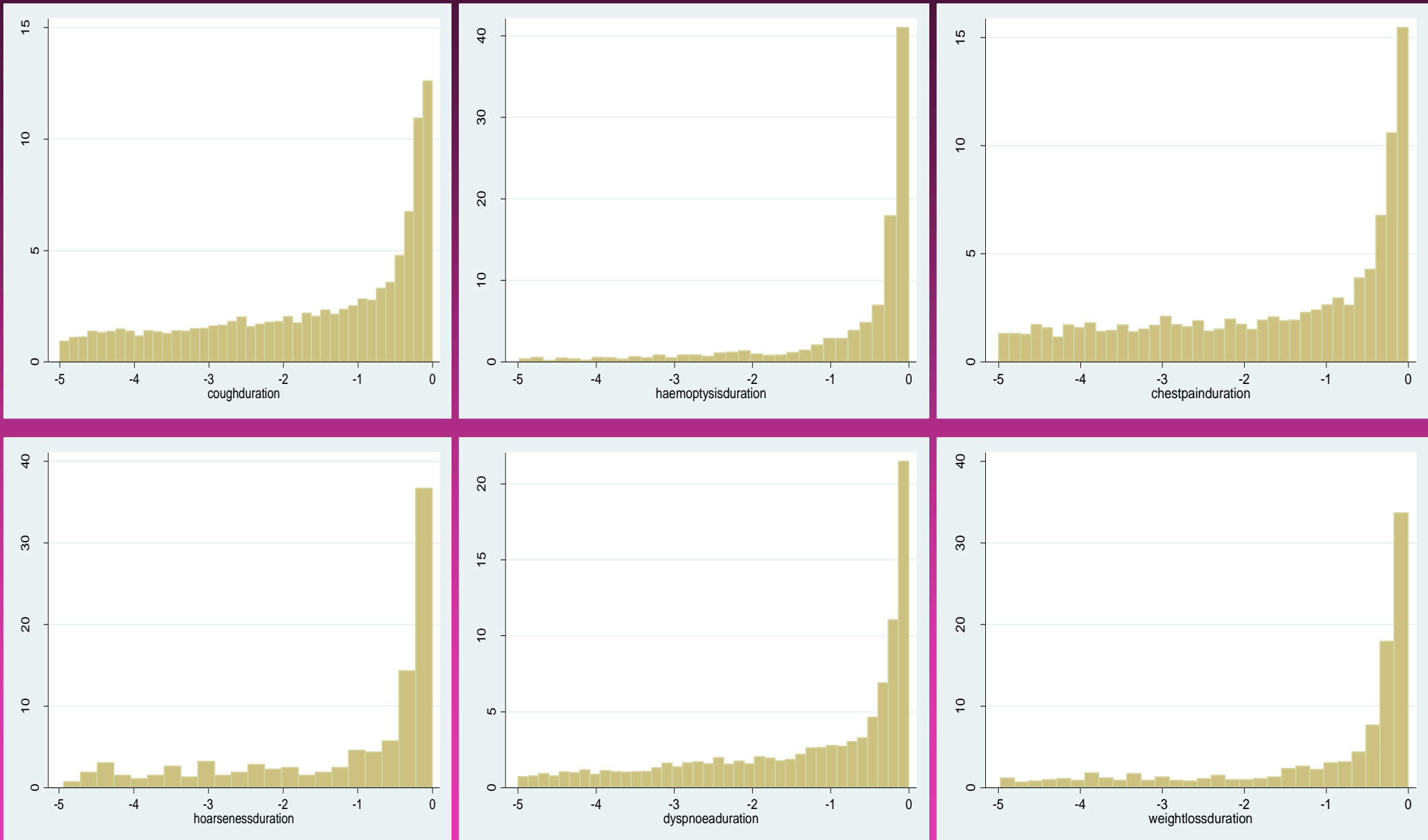
- **1. People are made aware of the symptoms and signs of lung cancer through local coordinated public awareness campaigns that result in early presentation.**
 - **Structure**
 - Evidence of local arrangements to ensure that people are made aware of the symptoms and signs of lung cancer through local coordinated public awareness campaigns that result in early presentation.
 - **Process**
 - Proportion of people newly diagnosed with lung cancer who were identified as a result of a local public awareness campaign.
 - **Outcome**
 - a) emergency admissions
 - b) 3-month and 1-year survival
 - c) Public awareness of symptoms and signs of lung cancer.
 - d) Stage at diagnosis.

Symptoms significantly associated with diagnosis of lung cancer (..so far)

Symptom	Cases (%)	Controls (%)	Odds ratio	95% CI	P-value
Cough					
2yrs before lung ca index	39.5	16.1	3.70	3.50-3.90	<0.001
1yr before lung ca index	33.3	10.1	4.77	4.49-5.07	<0.001
Haemoptysis					
2yrs before lung ca index	11.2	0.4	32.7	27.0-39.6	<0.001
1yr before lung ca index	10.45	0.2	54.7	42.5-70.4	<0.001
Chest/shoulder pain					
2yrs before lung ca index	25.2	11.2	2.75	2.58-2.92	<0.001
1yr before lung ca index	20.35	6.6	3.67	3.42-3.93	<0.001
Voice hoarseness					
2yrs before lung ca index	2.8	0.65	4.32	3.59-5.20	<0.001
1yr before lung ca index	2.3	0.35	6.7	5.34-8.4	<0.001
Difficulty in breathing					
2yrs before lung ca index	26.65	7.75	4.79	4.48-5.12	<0.001
1yr before lung ca index	23	5	6.4	5.93-6.91	<0.001
Weight loss					
2yrs before lung ca index	6.65	1.2	6.17	5.41-7.04	<0.001
1yr before lung ca index	6	0.7	9.86	8.39-11.6	<0.001

Source: R Hubbard; unpublished

Record of symptoms among cases 5 years before lung cancer index date



Source: R Hubbard; unpublished

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- **People reporting one or more symptoms suggesting lung cancer are referred within 1 week of presentation for a chest X-ray or directly to a chest physician who is a core member of the lung cancer multidisciplinary team.**
 - **Structure**
 - Evidence of local arrangements and written clinical protocols
 - **Process**
 - a) Proportion of people reporting one or more symptoms suggesting lung cancer who are referred within 1 week of presentation
 - b) Proportion of people with lung cancer who saw their GP about symptoms suggesting lung cancer no more than twice in the last 6 months
 - **Outcome**
 - Chest X-ray referral rates in people over 50 years.

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People with a chest X-ray result suggesting lung cancer have a copy of the radiologist's report sent to and followed up by the lung cancer multidisciplinary team

- **Structure**
 - Evidence of local arrangements and written clinical protocols
- **Process**
 - Proportion of people with a chest X-ray result suggesting lung cancer who have a copy of the radiologist's report sent to and followed up by the lung cancer multidisciplinary team.

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- **People with known or suspected lung cancer have access to a named lung cancer clinical nurse specialist who they can contact between scheduled hospital visits.**
 - **Structure**
 - Evidence of local arrangements and written clinical protocols
 - **Process**
 - a) Proportion of people with known or suspected lung cancer who have been given the name and contact number of a lung cancer clinical nurse specialist who they can contact between scheduled hospital visits.
 - b) Proportion of people with lung cancer who had a lung cancer clinical nurse specialist present at diagnosis.
 - c) Proportion of people with lung cancer who have been assessed by a lung cancer clinical nurse specialist.
 - **Outcome**
 - Patient satisfaction with access to and support from a lung cancer clinical nurse specialist.

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- **People with lung cancer are offered a holistic needs assessment at each key stage of care that informs their care plan and the need for referral to specialist services.**
- **Structure**
 - Evidence of local arrangements and written clinical protocols
- **Process**
 - a) Proportion of people with lung cancer who have a care plan based on a holistic needs assessment undertaken at diagnosis.
 - b) Proportion of people with lung cancer who have a care plan based on a holistic needs assessment undertaken at diagnosis and other key stages of care.
 - c) Proportion of people with lung cancer who receive specialist services as a result of a care plan based on a holistic needs assessment.
- **Outcome**
 - a) Patient satisfaction with support offered.
 - b) Patient satisfaction with support received.

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- People with lung cancer following initial assessment and CT scan are offered investigations that give the most information about diagnosis and staging with the least risk of harm
 - Structure
 - Evidence of local arrangements and written clinical protocols
 - Process
 - a) Proportion of people with lung cancer following initial assessment and CT scan who have **pathologically confirmed mediastinal staging**.
 - b) Proportion of people with lung cancer following initial assessment and CT scan who receive **two or more invasive tests** for diagnostic and staging purposes.
 - Outcome
 - a) Complications following invasive or minimally invasive tests.
 - b) Histological confirmation rate.
 - c) People with lung cancer who have stage recorded.

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- **People with lung cancer have adequate tissue samples taken in a suitable form to provide a complete pathological diagnosis including tumour typing and sub-typing, and analysis of predictive markers**
 - **Structure**
 - Evidence of local arrangements and written clinical protocols
 - **Process**
 - a) Proportion of people with lung cancer who have a second diagnostic test in order to obtain additional pathological information.
 - b) Proportion of people with lung cancer who have a pathological diagnosis.
 - c) Proportion of people with lung cancer who have a tumour type identified.
 - d) Proportion of people with non-small-cell lung cancer who have a tumour sub-type identified.
 - e) Proportion of people with non-small-cell lung cancer where reported tumour sub-type is 'not otherwise specified'.
 - f) Proportion of people with lung cancer who have an analysis of predictive markers.

- **People with resectable lung cancer who are of borderline fitness and not initially accepted for surgery are offered the choice of a second surgical opinion, and a multidisciplinary team opinion on non-surgical treatment with curative intent**
 - **Structure**
 - Evidence of local arrangements and written clinical protocols
 - **Process**
 - a) Proportion of people with resectable lung cancer who are of borderline fitness and not initially accepted for surgery who are offered the choice of a second surgical opinion, and a multidisciplinary team opinion on non-surgical treatment with curative intent.
 - b) Proportion of people with resectable lung cancer who are of borderline fitness and not initially accepted for surgery who receive non-surgical treatment with curative intent.
 - **Outcome**
 - a) 30-day mortality rates following surgical resection.
 - b) 60-day mortality rates following surgical resection.
 - c) Resection rates.

- **People with lung cancer are offered assessment for multimodality treatment by a multidisciplinary team comprising all specialist core members**
 - **Structure**
 - Evidence of local arrangements and written clinical protocols
 - **Process**
 - Proportion of people with lung cancer who receive assessment for multimodality treatment by a multidisciplinary team comprising all specialist core members.
 - **Outcome**
 - a) Surgery rates.
 - b) Multimodality rates.
 - c) Radiotherapy rates.
 - d) Overall active treatment rates.
 - e) Chemotherapy rate for small-cell lung cancer.
 - f) Chemotherapy rate for stage IIIB and IV (performance status 0 and 1) non-small-cell lung cancer.

- **People with lung cancer stage I-III and good performance status who are unable to undergo surgery are assessed for radiotherapy with curative intent by a clinical oncologist specialising in thoracic oncology**
 - **Structure**
 - Evidence of local arrangements and written clinical protocols
 - **Process**
 - Proportion of people with lung cancer stage I-III and good performance status who are assessed for radiotherapy with curative intent by a clinical oncologist specialising in thoracic oncology.

- **People with lung cancer stage I-III and good performance status who are offered radiotherapy with curative intent receive planned treatment techniques that optimise the dose to the tumour while minimising the risks of normal tissue damage**
 - **Structure**
 - Evidence of local arrangements and written clinical protocols
 - **Process**
 - a) Proportion of people with lung cancer stage I-III and good performance status who receive radiotherapy with curative intent.
 - b) Proportion of people with lung cancer receiving radiotherapy with curative intent who receive planned treatment techniques that optimise the dose to the tumour while minimising the risks of normal tissue damage.

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- **People with stage IIIB or IV non-small-cell lung cancer and eligible performance status are offered systemic therapy (first- and second-line) in accordance with NICE guidance, that is tailored to the pathological sub-type of the tumour and individual predictive factors**
 - **Structure**
 - Evidence of local arrangements and written clinical protocols
 - **Process**
 - a) Proportion of people with stage IIIB or IV non-small-cell lung cancer and eligible performance status who receive first-line systemic therapy in accordance with NICE guidance, that is tailored to the pathological sub-type of the tumour and individual predictive factors.
 - b) Proportion of people with advanced stage IIIB or IV non-small-cell lung cancer and eligible performance status who receive second-line systemic therapy in accordance with NICE guidance, that is tailored to the pathological sub-type of the tumour and individual predictive factors

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- **People with small-cell lung cancer have treatment initiated within 2 weeks of the pathological diagnosis**
 - **Structure**
 - Evidence of local arrangements and written clinical protocols to ensure that people with small-cell lung cancer have treatment initiated within 2 weeks of the pathological diagnosis.
 - **Process**
 - Proportion of people with small-cell lung cancer who have treatment initiated within 2 weeks of the pathological diagnosis.

- **People with lung cancer are offered a specialist follow-up appointment within 6 weeks of completing initial treatment and regular specialist follow-up thereafter, which can include protocol-led clinical nurse specialist follow-up**
 - **Structure**
 - Evidence of local arrangements and written clinical protocols
 - **Process**
 - a) Proportion of people with lung cancer who receive a specialist follow-up appointment within 6 weeks of completing initial treatment.
 - b) Proportion of people with lung cancer who receive regular specialist or protocol-led clinical nurse specialist follow-up after completing initial treatment.

- **People with lung cancer have access to all appropriate palliative interventions delivered by expert clinicians and teams**
 - **Structure**
 - Evidence of local arrangements and written clinical protocols
 - **Process**
 - a) Proportion of people with lung cancer and bronchial obstruction who receive endobronchial treatments.
 - b) Proportion of people with lung cancer and pleural effusion who receive pleural aspiration or drainage.

Quality Statements – what's missing?

- **Specific Palliative Care recommendations**
 - Covered by generic QS
 - Palliative Care
 - Patient experience
- **Specific recommendations on communication**
 - Covered by generic QS
 - Patient experience

COF – Operational from April 2013

- **Draft indicators are developed from NICE quality standards and are reviewed by a topic-specific review group.**
- **Indicators considered as clear and valid are then presented to the COF advisory Committee, which selects indicators for further development and testing.**
- **NICE works with the NHS Information Centre to further develop and test indicators.**

What Now?

- **Pre-meeting to discuss indicators**
- **Meeting of TEG in May**
- **Suggestions most welcome!**