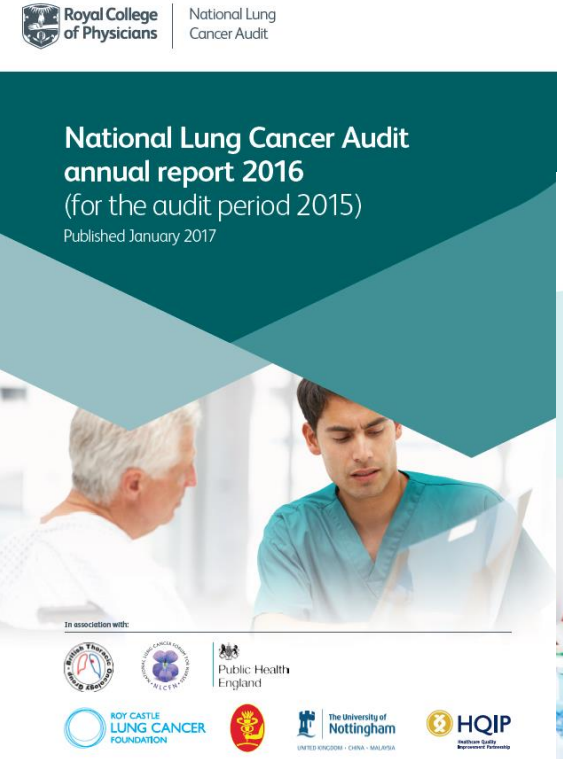
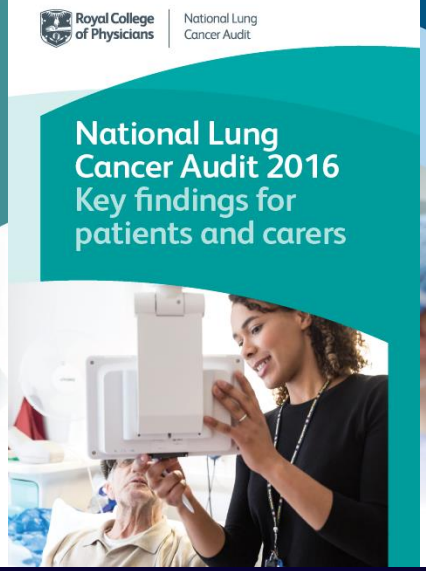
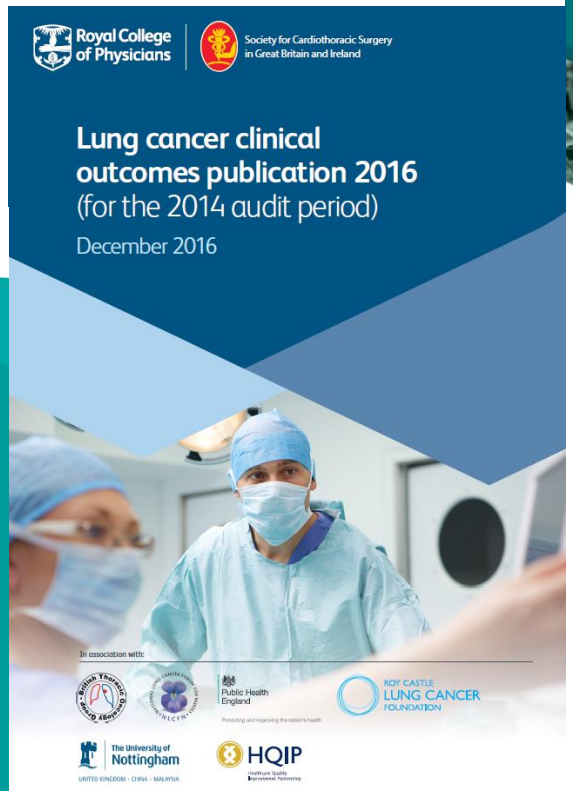
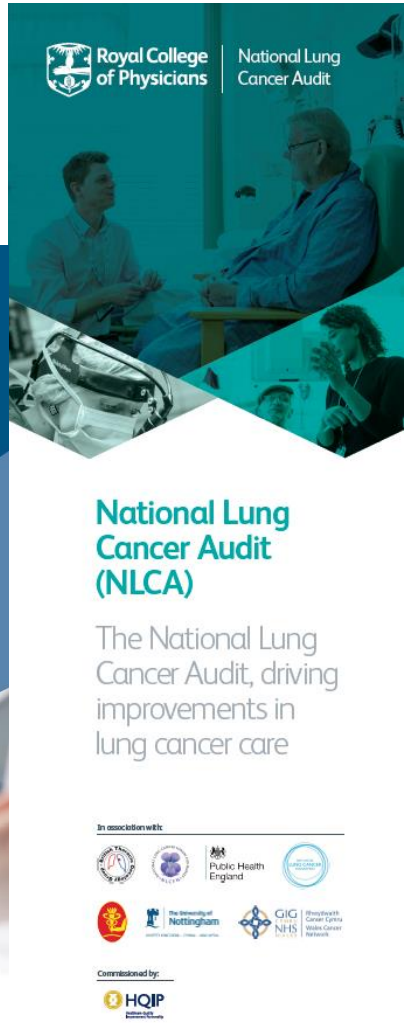
National Lung Cancer Audit









Team members:

- Rosie Dickinson, project manager
- Hannah Rodgers, project coordinator

- Paul Beckett, senior clinical lead
- Susan Harden, co-clinical lead
- Neal Navani, co-clinical lead

- Natasha Wood, audit project manager at the NCRAS, PHE

- Aamir Khakwani, research associate
- Richard Hubbard, professor of respiratory epidemiology

- Doug West, thoracic audit lead

The NCAPOP project journey so far

The NLCA has been collecting data since 2005 and in 2015 started collecting via the Cancer Outcomes and Services Dataset (COSD). In combining these COSD submissions with registry data at the National Cancer Registration and Analysis Service (NCRAS) we have created a much fuller dataset to analyse and draw results from.

As such we can now turn our attention to encouraging and helping to implement quality improvement in lung cancer teams.

Local QI visits to networks in England, using local results to start discussions on how to improve the lung cancer pathway in that trust. A couple of these visits have featured in our blog www.rcplondon.ac.uk/nlcablog

Quality improvement visit: Cheshire and Merseyside

Produced by:
National Lung Cancer Audit (NLCA) blog

NLCA clinical lead Paul Beckett discusses his quality improvement (QI) visit to the North West.

I recently attended a meeting of the Cheshire and Merseyside Strategic Clinical Network (SCN) lung cancer subgroup at Aintree University Hospital in Liverpool as part of the National Lung Cancer Audit's (NLCA's) aim to raise awareness of the programme, to encourage local discussion of results and to try to stimulate quality improvement. Knowing that prior to the publication of our recent NLCA annual report 2016 several of the trusts had been concerned about the accuracy of their data, I set off with some trepidation.

Our **Improving Lung Cancer Outcomes Project** (ILCOP) brought together multidisciplinary healthcare teams from different NHS trusts to share best practice in diagnosing, treating and supporting patients with lung cancer, to ensure improvements in survival and quality of life

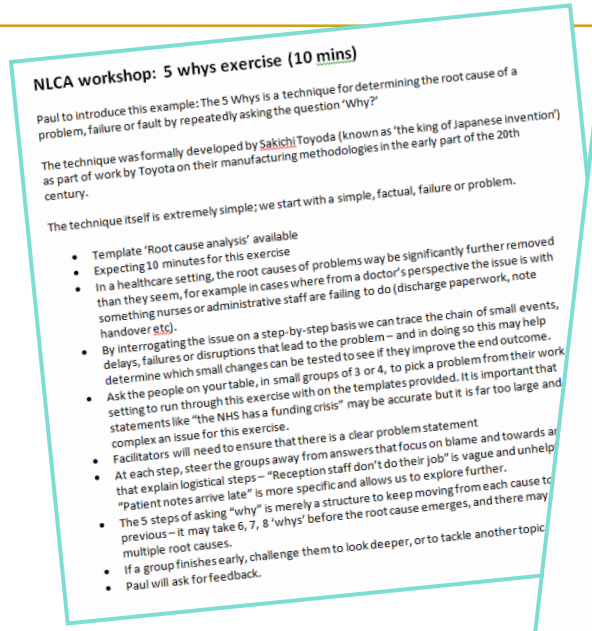
All Teach, All Learn

We held 2 **QI workshops** in 2017

- London, June 2017
- Leeds, September 2017

Delegates were asked to share 'one good thing' from their trust that they felt had improved their service. They completed several QI activities including the '5 whys' and the PDSA cycle.

During these workshops, delegates were asked to provide a 'commitment' – an action they would implement as a result of what they had learnt on the day. The NLCA have grouped the commitments thematically and will be creating workgroups to help trusts work together to improve care in their trusts.



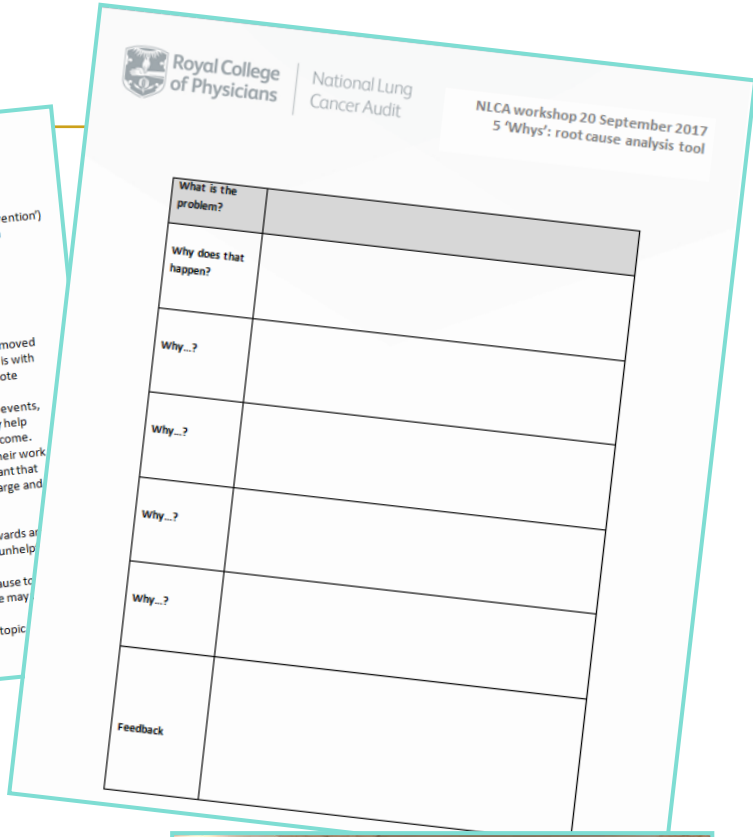
NLCA workshop: 5 whys exercise (10 mins)

Paul to introduce this example: The 5 Whys is a technique for determining the root cause of a problem, failure or fault by repeatedly asking the question 'Why?'

The technique was formally developed by Sakichi Toyoda (known as 'the king of Japanese invention') as part of work by Toyota on their manufacturing methodologies in the early part of the 20th century.

The technique itself is extremely simple; we start with a simple, factual, failure or problem.

- Template 'Root cause analysis' available
- Expecting 10 minutes for this exercise
- In a healthcare setting, the root causes of problems way be significantly further removed than they seem, for example in cases where from a doctor's perspective the issue is with something nurses or administrative staff are failing to do (discharge paperwork, note handover etc).
- By interrogating the issue on a step-by-step basis we can trace the chain of small events, delays, failures or disruptions that lead to the problem – and in doing so this may help determine which small changes can be tested to see if they improve the end outcome.
- Ask the people on your table, in small groups of 3 or 4, to pick a problem from their work setting to run through this exercise with on the templates provided. It is important that statements like "the NHS has a funding crisis" may be accurate but it is far too large and complex an issue for this exercise.
- Facilitators will need to ensure that there is a clear problem statement
- At each step, steer the groups away from answers that focus on blame and towards ar that explain logistical steps – "Reception staff don't do their job" is vague and unhelp "Patient notes arrive late" is more specific and allows us to explore further.
- The 5 steps of asking "why" is merely a structure to keep moving from each cause to previous – it may take 6, 7, 8 'whys' before the root cause emerges, and there may multiple root causes.
- If a group finishes early, challenge them to look deeper, or to tackle another topic
- Paul will ask for feedback.



Royal College of Physicians | National Lung Cancer Audit

NLCA workshop 20 September 2017
5 'Whys': root cause analysis tool

What is the problem?	
Why does that happen?	
Why...?	
Why...?	
Why...?	
Why...?	
Feedback	

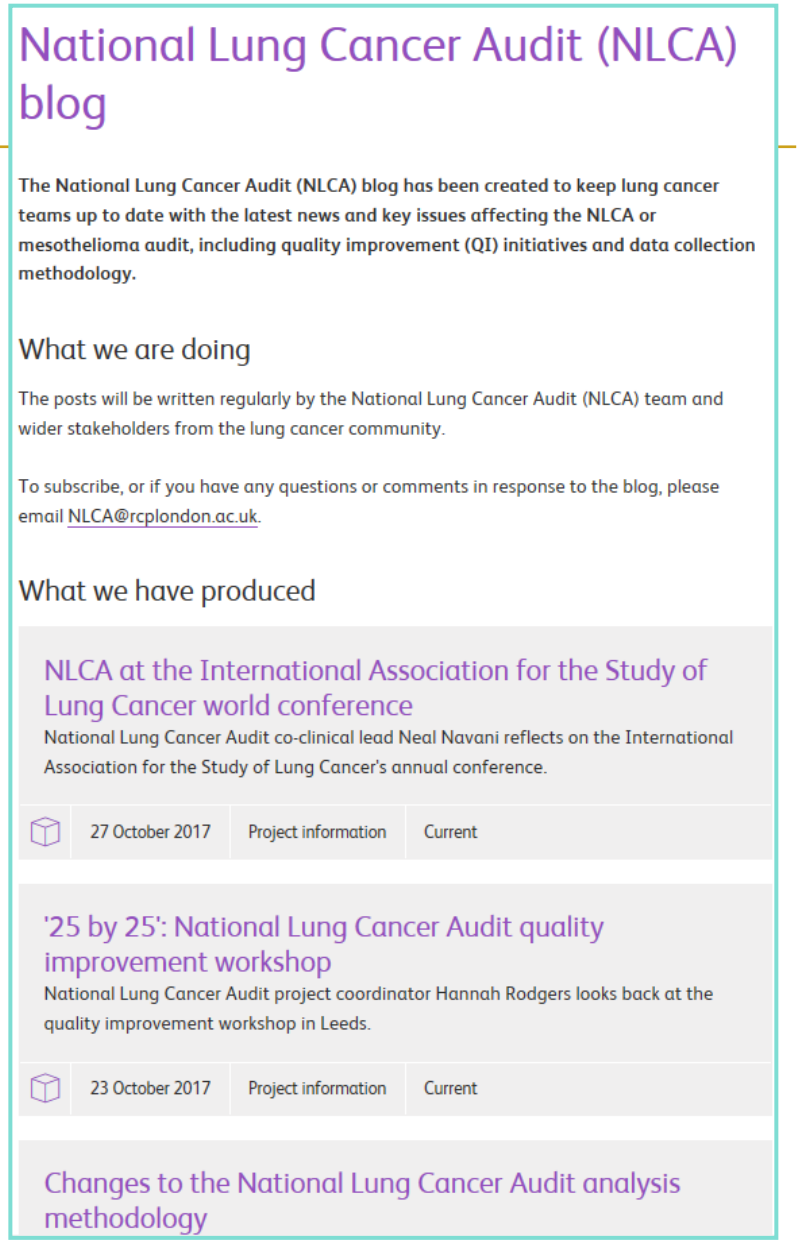
CNS-led follow up clinics, alternating with consultant clinic follow up – **One good thing, London workshop**

Insights from work

1. Some topics have to be communicated in a lot of detail; this was how our blog started. If a topic needs more explaining, just sending emails might not be the best way of communicating them.

2. Tailor your messages. If a subject is complex, say upfront that it is and then go through and explain it carefully.

3. Be present. Previously, we were not in touch with trusts as much as we could have been which led to a lot of questions from them. By being more consistent, it prevents gaps in knowledge and makes it easier for the audit team and the trusts.



National Lung Cancer Audit (NLCA) blog

The National Lung Cancer Audit (NLCA) blog has been created to keep lung cancer teams up to date with the latest news and key issues affecting the NLCA or mesothelioma audit, including quality improvement (QI) initiatives and data collection methodology.

What we are doing

The posts will be written regularly by the National Lung Cancer Audit (NLCA) team and wider stakeholders from the lung cancer community.

To subscribe, or if you have any questions or comments in response to the blog, please email NLCA@rcplondon.ac.uk.

What we have produced

NLCA at the International Association for the Study of Lung Cancer world conference

National Lung Cancer Audit co-clinical lead Neal Navani reflects on the International Association for the Study of Lung Cancer's annual conference.

27 October 2017 | Project information | Current

'25 by 25': National Lung Cancer Audit quality improvement workshop

National Lung Cancer Audit project coordinator Hannah Rodgers looks back at the quality improvement workshop in Leeds.

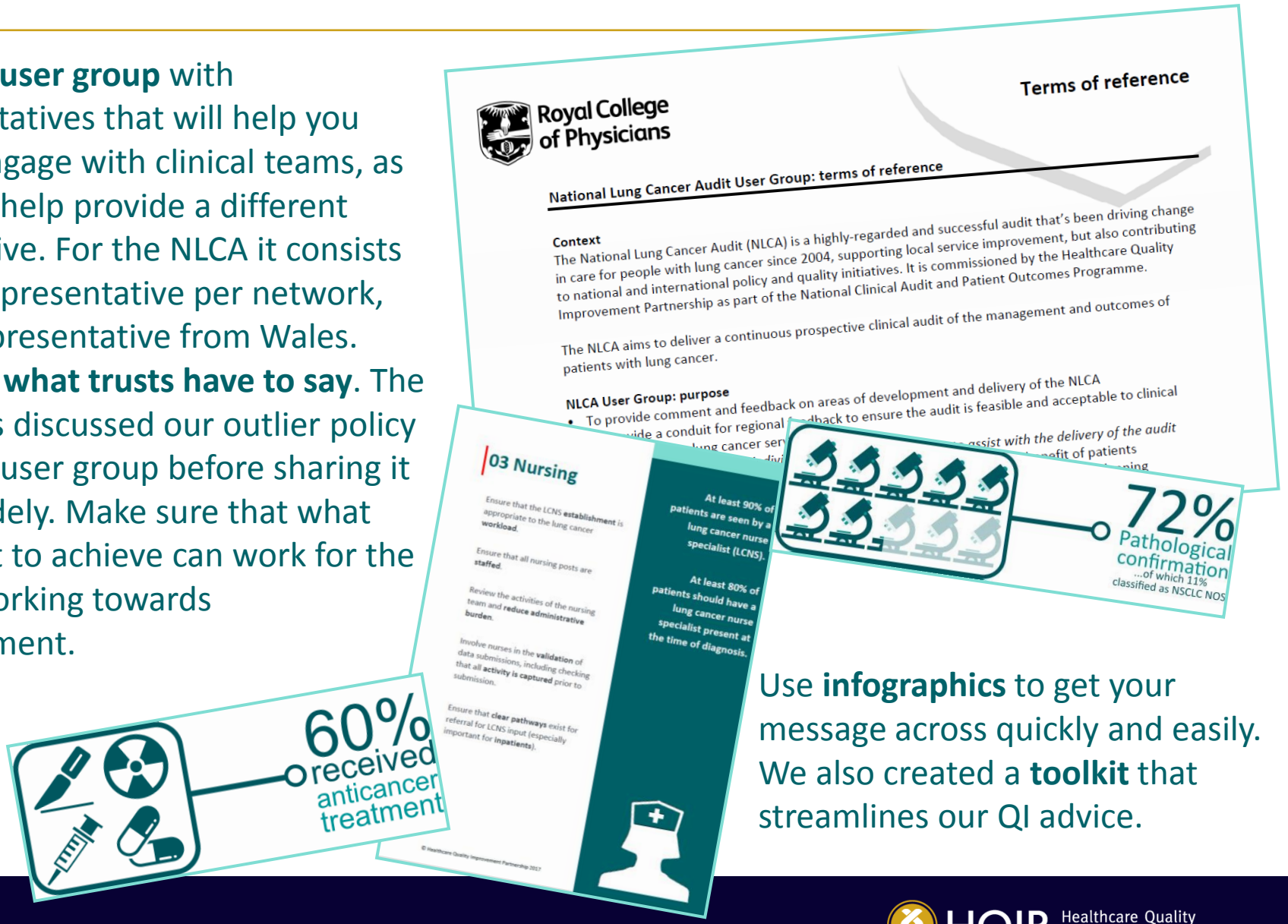
23 October 2017 | Project information | Current

Changes to the National Lung Cancer Audit analysis methodology

Advice to peers

Create a user group with representatives that will help you better engage with clinical teams, as they will help provide a different perspective. For the NLCA it consists of one representative per network, and a representative from Wales.

Listen to what trusts have to say. The NLCA has discussed our outlier policy with our user group before sharing it more widely. Make sure that what you want to achieve can work for the teams working towards improvement.

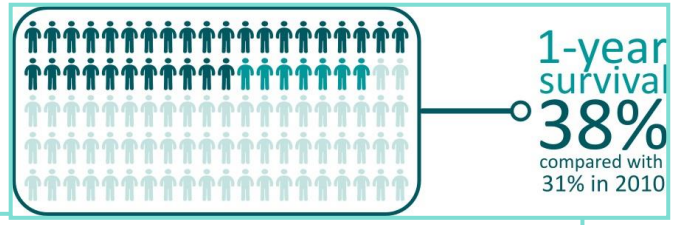


Use **infographics** to get your message across quickly and easily. We also created a **toolkit** that streamlines our QI advice.

We are keen to learn:

- Other techniques of how to encourage QI, and QI communication, among clinical teams
  - Eg newsletters, workshops
- What has worked and what has not worked so well
- Do teams evaluate how successful these have been and if so, how do they measure it?

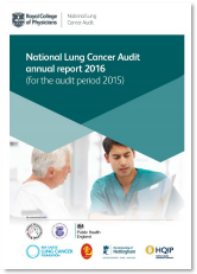
Sharing effective and impactful ways of presenting data/recommendations



Appendix 2

NLCA toolkit

Improving lung cancer care



Staff working in lung cancer teams want to deliver the best care possible for their patients, but the NLCA analysis shows marked variation in standards of care across different organisations, indicating that this may not always be the case. In the 2016 annual report, we make 13 recommendations to improve care, and here we provide a toolkit to help organisations achieve them.

- Data quality
- Pathology
- Specialist nursing
- Treatment
- Surgery
- Chemotherapy

The NLCA team are always happy to discuss your results, and 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

01 Data quality

Appoint a **clinical data lead** to take responsibility for understanding the dataset and the data collection process.

Raise the profile of performance data across the wider MDT at governance meetings or by sharing data.

Use **CancerStats** website to review data quality in real time.

Integrate data collection into **MDT meetings**.

Integrate **clinical validation** into the COSD submission process.

Check that **key fields** are completed prior to COSD submission.

Work with NCRAS **data improvement leads** to understand cases **missed by COSD**.

Improve the quality of data submitted to the NLCA.

PS and stage should be recorded in at least 90% of cases.

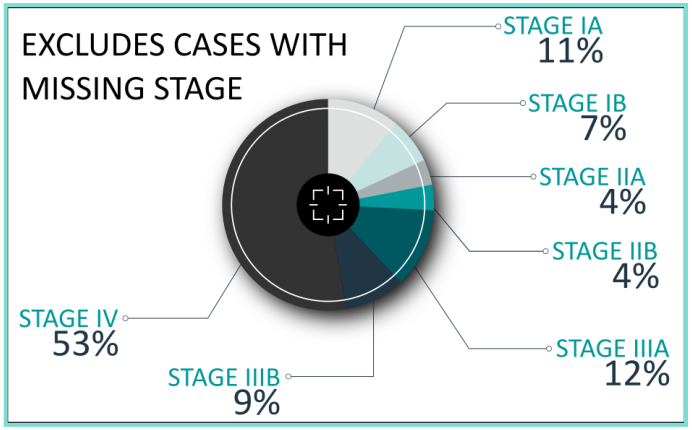
Complete the FEV1 and FEV1% fields in relevant patients.

Ensure that the COSD 'place first seen' is completed in all submissions.

Quality improvement visit: North West Coast

Produced by:
National Lung Cancer Audit (NLCA) blog

National Lung Cancer Audit (NLCA) clinical lead Susan Harden writes about her quality improvement visit to the North West.

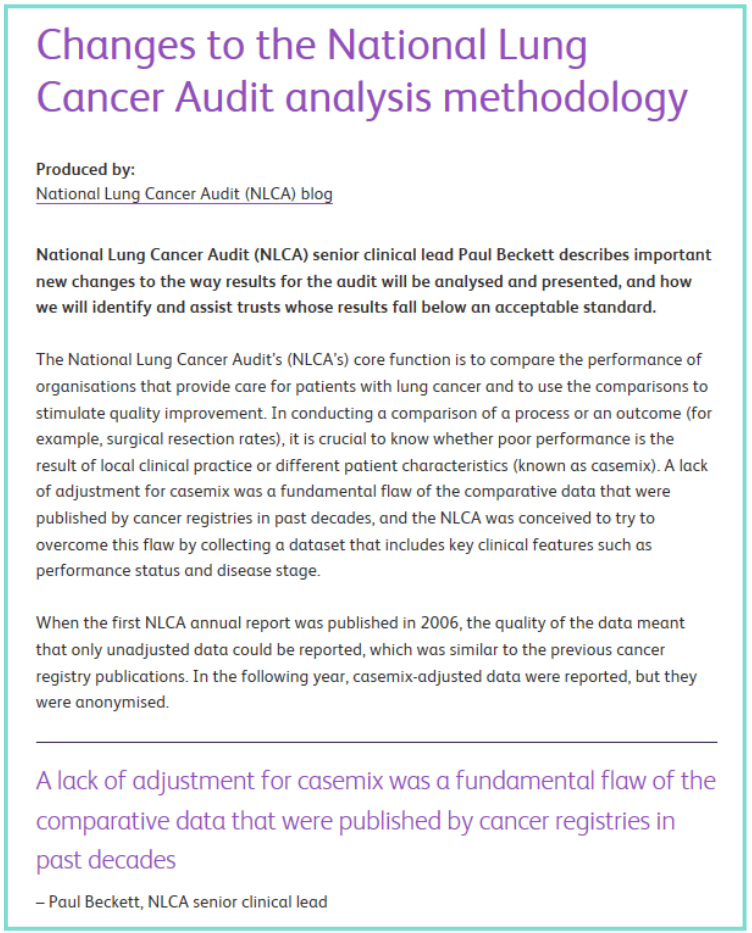


Next Steps

- New **methodology** – more meaningful. Funnel plot charts. In line with LCCOP, more consistent

- Shorter, more **succinct reports**, more information **online**. The 2016 annual report was 70 pages, our next one will be 30 pages.

- The NLCA might start using **webinars** soon to help clinical teams work together on QI. These will be based on themes picked up on from **commitments** made at the workshop



Changes to the National Lung Cancer Audit analysis methodology

Produced by:
National Lung Cancer Audit (NLCA) blog

National Lung Cancer Audit (NLCA) senior clinical lead Paul Beckett describes important new changes to the way results for the audit will be analysed and presented, and how we will identify and assist trusts whose results fall below an acceptable standard.

The National Lung Cancer Audit's (NLCA's) core function is to compare the performance of organisations that provide care for patients with lung cancer and to use the comparisons to stimulate quality improvement. In conducting a comparison of a process or an outcome (for example, surgical resection rates), it is crucial to know whether poor performance is the result of local clinical practice or different patient characteristics (known as casemix). A lack of adjustment for casemix was a fundamental flaw of the comparative data that were published by cancer registries in past decades, and the NLCA was conceived to try to overcome this flaw by collecting a dataset that includes key clinical features such as performance status and disease stage.

When the first NLCA annual report was published in 2006, the quality of the data meant that only unadjusted data could be reported, which was similar to the previous cancer registry publications. In the following year, casemix-adjusted data were reported, but they were anonymised.

A lack of adjustment for casemix was a fundamental flaw of the comparative data that were published by cancer registries in past decades

– Paul Beckett, NLCA senior clinical lead

How can HQIP help?

- Promoting our work and outputs with wider stakeholders

Presentations at NCAPOP seminar

- Your team will present their story board to others during the seminar
- Have a think about who will present
- You can have more than one team member presenting
- Try not to go over the allocated slides as you will not be able to put all the pages onto the story board (16 maximum)
- The length of presentations will be limited to 5 minutes
- You will be clustered into groups with other providers based on your story board; however at least one member of your team should go to or participate in other clusters