



Royal College  
of Physicians

National Lung  
Cancer Audit

# Organisational audit report

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### National Lung Cancer Audit

The National Lung Cancer Audit (NLCA) is commissioned by HQIP. The NLCA is a programme of work that aims to improve the quality of care, services and clinical outcomes for patients with lung cancer in England, Scotland and Wales. To find out more about the NLCA visit [www.rcplondon.ac.uk/projects/national-lung-cancer-audit](http://www.rcplondon.ac.uk/projects/national-lung-cancer-audit).

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**5%**

of trusts / health boards met the recommended 'time commitments' for specialist staff.

**44%**

achieved the recommended 3-day turnaround for pathological subtyping and 37% achieved molecular diagnostics within 10 days.

**47%**

of trusts / health boards had a policy for the treatment of tobacco addiction.

**71%**

of trusts / health boards discussed 30 patients or fewer in a 2-hour MDT meeting.

MDT = multidisciplinary team

**67%**

of units had an MDT member with responsibility for data quality.

Local onsite access to specialist services **varied** nationally.

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## Executive summary

This is the third National Lung Cancer Audit (NLCA) organisational report, previous reports having been published in 2014 and 2017. The report aims to reassess the provision of lung cancer services in secondary care across England and Wales, since the last audit period. The report also seeks to highlight any variation in diagnostics, treatment modalities and specialist staffing; provide information for national benchmarking; and measure the extent to which the recommendations made in the 2017 report have been met. A total of 160 units were invited to take part in the organisational survey of which 141 units provided responses (a participation rate of 88%), an improvement from a participation rate of 86% in the 2017 audit and 57% participation rate in 2014.

Key findings across the organisations surveyed included:

1. Only 5% of units (8% in 2017) had adequate levels of specialist staffing in all of five key areas.
2. Less than half (44%) achieved the recommended 3-day turnaround for pathological subtyping and 37% achieved molecular diagnostics within 10 days, which may have led to delays in treatment for some patients.
3. Local on-site access to specialist services varied nationally – for some diagnostic tests such as bronchoscopy and cardiopulmonary physiology testing, there was near universal on-site provision. However, ease and speed of access to other tests was likely to have been compromised by more limited on-site access to (for example) endobronchial ultrasound (EBUS) in 76%, local anaesthetic thoracoscopy in 47% and positron emission tomography (PET) computed tomography (CT) (PET-CT) in 28%. Similarly, palliative and supportive care was available on-site at 96% of units but immunotherapy only at 81%.
4. The workload in multidisciplinary team (MDT) meetings appeared to have become more manageable; 71% of units (29% in 2017) discussed 30 patients or fewer in a 2-hour MDT meeting. However, attendance of key staff at treatment MDT meetings varied with 74% of MDTs having a medical oncologist and 86% with specialist palliative care representation.
5. Two-thirds (67%) of units had an MDT member with responsibility for data quality and of these only 18% had time in their job plan for this role.
6. Only 47% of units had a policy for the treatment of tobacco addiction and pharmacotherapy was prescribed in only 37%.

While there is scope to improve services at a local level, it is likely that regional and national coordination and action will need to be undertaken, including investment in staffing and infrastructure, to bring services in line with recommendations and ambitions.

## Recommendations

Recommendation	Result / page in the report	Standard/guidance	Key audience
<p>1 A gap analysis of local staffing levels should be undertaken by cancer MDTs against national service guidance (NOLCP<sup>1</sup> and NSGC<sup>2</sup>). The results of the gap analysis should be used by cancer alliances and commissioners to inform and support local and regional action planning to improve staffing.</p>	<p>5% of sites met recommendations for specialist time commitment as per the NSGC (page 12).</p>	<p>NSGC guidance: For each secondary care provider there should be access to:</p> <ul style="list-style-type: none"> <li>&gt; one WTE (10 PAs) respiratory physician for DCC per 200 new diagnoses per year</li> <li>&gt; radiologists with at least a third of their job plan devoted to thoracic imaging direct clinical care</li> <li>&gt; medical and clinical oncologists with at least one third of their job plan devoted to lung cancer DCC</li> <li>&gt; one WTE LCNS per 80 new diagnoses per year.</li> </ul>	<p>Trust- / health board-level executives, commissioners, cancer alliances.</p>
<p>2 Lung cancer teams who do not meet targets for pathological subtyping and molecular testing should work with their pathology providers to process map these pathways in order to improve performance.</p>	<p>44% of units achieved pathological subtyping within 3 days and 37% achieved molecular diagnostics within 10 days (page 10).</p>	<p>NOLCP.</p>	<p>Clinical leads, MDTs.</p>
<p>3 Where diagnostic/staging investigations and treatments are not available on-site at the local hospital, cancer alliances should work with providers to ensure that all patients in the region are achieving equitable and timely access.</p>	<p>Many trusts / health boards did not have access to local on-site investigations and treatments (Table 1 and Table 2).</p>	<p>NSGC guidance:</p> <ul style="list-style-type: none"> <li>&gt; there must be prompt access to locally or centrally provided expert diagnostic, staging and fitness assessment</li> <li>&gt; all patients receive agreed treatment that is consistent and equitable.</li> </ul>	<p>Clinical leads, MDTs, trust- / health board-level executives.</p>
<p>4 Lung cancer clinical leads should have protected time in their job plans to allow them to carry out the role effectively.</p>	<p>The lead clinician had dedicated time in their job plan for this role in 62% of sites (page 12).</p>	<ul style="list-style-type: none"> <li>&gt; Target standard proposed by the NLCA (2019).</li> </ul>	<p>Clinical leads, trust- / health board-level executives.</p>

5	Every lung cancer team should appoint an MDT member with responsibility for data quality with protected time in their job plan to allow them to carry out the role effectively.	67% of units had an MDT member with responsibility for data quality, and of these only 18% had time in their job plan for this role (page 12).	NLCA annual report: <sup>3</sup> > all lung cancer MDTs should appoint a 'clinical data lead' with protected time to allow promotion of data quality, governance and QI, and to ensure that data submitted undergoes clinical validation and assessment for data completeness.	Clinical leads, MDTs, trust- / health board-level executives.
6	Lung cancer teams should ensure that their patient-facing staff are all trained in delivering 'very brief advice' on smoking cessation, and that members of the team are trained to deliver treatment for tobacco addiction. Work with local smoking cessation services should also be undertaken to develop pathways suitable for these patients.	<ul style="list-style-type: none"> <li>&gt; 47% of sites had a policy for treating tobacco addiction in patients being assessed through the lung cancer pathway (page 11).</li> <li>&gt; 37% of sites prescribed pharmacological treatment for tobacco addiction from within the lung cancer service (page 11).</li> </ul>	NSGC guidance / NICE guidelines: > smoking cessation therapies should be offered to all patients and by all care providers involved in the patients' care.	Clinical leads, MDTs, commissioners.
7	Lung cancer teams should work with local pulmonary rehabilitation services to develop pathways suitable for these patients.	61% of sites had a local pulmonary rehabilitation service for patients on the lung cancer pathway (page 11).	NSGC guidance: > rehabilitation is an important aspect of supportive care. There should be appropriate assessment of patient's rehabilitative needs across the pathway and the provider must ensure that high-quality rehabilitation is provided. This should involve an agreed recovery package and may include pulmonary rehabilitation delivered pre- or post-treatment to improve dyspnoea and fatigue.	Clinical leads, MDTs, commissioners.

DCC = direct clinical care; LCNS = lung cancer nurse specialist; MDT = multidisciplinary team; NOLCP = National Optimal Lung Cancer Pathway; NSGC = National Service Guidance for Commissioners; PAs = programmed activities; WTE = whole time equivalent

## Background

The National Lung Cancer Audit (NLCA) is commissioned by the Healthcare Quality Improvement Partnership (HQIP). The NLCA has been collecting data on the organisation of lung cancer services in England and Wales since 2014. Previous organisational audits have highlighted significant variation in service provision and workload of lung cancer specialists, and provided evidence that adherence to the national lung commissioning guidance has the potential to improve patient outcomes within the current service structure.<sup>4</sup>

The third organisational audit makes a reassessment of service provision as of June 2019, benchmarked against national recommendations. Its purpose is to understand currently available resources for the care of lung cancer patients and highlight variability. Defining such variability is critical in guiding policy on the minimum requirements that contribute to an effective lung cancer service that ensures all patients have access to the very best care.

The last organisational audit in 2017 made the following recommendations:

- All patients should have local access to smoking cessation and pulmonary rehabilitation services.
- All core multidisciplinary (MDT) members should have dedicated time to attend a weekly MDT meeting, discussing no more than 30 patients in 2 hours.
- All MDTs should ensure adequate specialist time commitment, as specified in the national commissioning guidance, with particular focus on clinical nurse specialists (CNS).
- All providers without a separate diagnostic MDT should implement one within the next 12 months as specified in the new commissioning guidance.

## Methodology

An electronic survey was sent to a nominated member of all lung cancer teams in England and Wales, requesting information that would provide a snapshot of lung cancer services in their organisations in June 2019. The questions were based on the 2017 survey but modified following feedback from the NLCA users group and chair of the Clinical Expert Group for Lung Cancer and Mesothelioma, NHS England.

Data was collected at a trust level (Health Board in Wales) with a designated lead clinician at each site having overall responsibility for data quality. A process of data checking and analysis was carried out in July by a specialist registrar working with the NLCA team.

The information collected and subsequent results have been benchmarked against standards reported in the National Service Guidance for Commissioners (NSGC)<sup>2</sup> which draws its evidence from a range of documents including National Institute for Health and Care Excellence (NICE) guidelines for the diagnosis and treatment of lung cancer<sup>5</sup> and a Department of Health document for cancer services specification.<sup>6</sup> Services are compared to 11 key indicators identified by the NSGC and that have been shown to have a direct impact on patient outcomes. The guidance recommending access to positron emission tomography (PET) computed tomography (CT) (PET-CT), endobronchial ultrasound (EBUS) and thoracoscopy within 7 days was mapped to each test being available on site.

Additional metrics from the NSGC are measured in this latest report. Finally, results were also compared with the recommendations made in the NLCA organisational audit in 2017. Where data is available, changes over time compared with previous audit rounds are reported.

## Results

A total of 141 responses were submitted from 160 units (88% participation rate). This compares to a participation rate of 86% in the 2017 audit and 57% participation rate in 2014.

### Diagnostic pathways

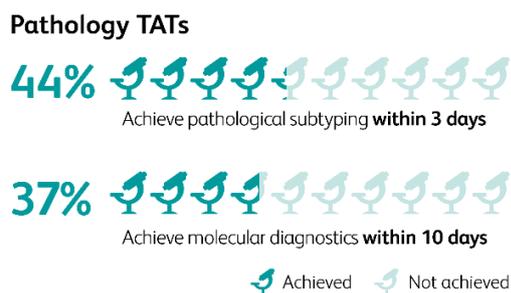
Overall, 72% of units had a 'straight to CT' pathway for patients with abnormal chest X-rays, and 75% of units had a pathway for triage of referrals to the service based on a CT scan result – in 73% of such cases, the triage occurred daily, and was usually done by a chest physician (86%), but sometimes by a radiologist or CNS. Two-thirds (66%) of units had a 'curative treatment' pathway where a bundle of tests were organised at the first outpatient visit, and 79% of units had a pathway for management of pulmonary nodules. Table 1 shows the availability of staging and diagnostic investigations.

**Table 1** Availability of staging and diagnostic investigations

Modality	On site	Off site	Unavailable
Bronchoscopy	99%	1%	
Echocardiogram	99%	1%	
Spirometry	99%	1%	
Gas transfer	98%	2%	
Radiological biopsy	95%	4%	1%
EBUS	76%	24%	
Cardiopulmonary exercise test	63%	32%	5%
Local anaesthetic thoracoscopy	47%	29%	24%
PET-CT	28%	71%	1%
PDL-1 status	24%	75%	1%
ALK mutation analysis	23%	76%	1%
Video-assisted thoracoscopy	22%	75%	3%
EGFR mutation analysis	19%	82%	1%
ROS-1 mutation analysis	12%	79%	9%

ALK = anaplastic lymphoma kinase; EBUS = endobronchial ultrasound; EGFR = epidermal growth factor receptor; PDL-1 = programmed death ligand 1; PET-CT = positron emission tomography computed tomography

**Fig 1 Pathology statistics**



The turnaround times (TATs) for pathological testing showed that less than half of trusts / health boards achieved pathological subtyping within 3 days, and only 37% achieved molecular diagnostics within 10 days (Fig 1). The separately published NLCA spotlight audit 2020 (England only), looked in more detail at these TATs, but evaluated patients diagnosed between June and December 2017 – median TATs were reported as 18 days for EGFR, 17

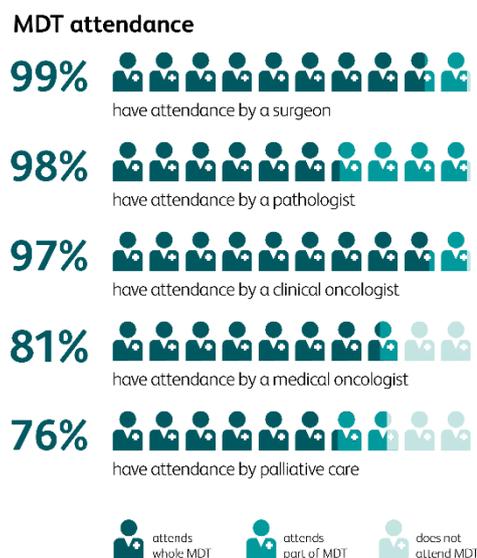
days for ALK and 17 days for PD-L1, and only a small number of trusts were able to meet the recommended 10-day target. Although this report suggests that there has been some improvement in performance, providers are encouraged to examine their local results and pathways, particularly if they did not participate in these audits.

### Multidisciplinary team working

MDT meetings are a feature of all lung cancer services. Just over half (54%) of units had a diagnostic MDT that was separate to the main treatment MDT (compared with 29% in 2014 and 44% in 2017). The majority of diagnostic MDTs (85%) ran weekly, but more frequent, even daily meetings, were a feature of a few services. Similarly, the treatment MDTs ran weekly in 91%, twice weekly in 6% and more frequently in 3%.

Attendance of key staff at treatment MDT meetings was variable, with 76% of MDTs having a palliative care specialist and 81% having a medical oncologist. It is relatively common for some staff to only attend part of the meeting (Fig 2).

**Fig 2 MDT attendance**



Treatment MDTs were most commonly 1–1.5 hours (36%), 1.5–2 hours (25%) or 2–2.5 hours (19%), but 5% reported that meetings last longer than 3 hours. Only 6.5% of treatment MDTs lasted <1 hour. There was a wide range of the number of cases discussed at the treatment MDT, between 6–70 patients, with a median of 25 patients discussed.

A considerable number of units reported diagnostic meetings of up to 4 hours but most lasted 1–1.5 hours (44%) or less than 1 hour (37%).

Just over half (51%) of units ran a multidisciplinary clinic where patients could access chest physicians, oncologists and surgeons in the same session.

**Fig 3 Patients discussed at a treatment MDT**



## Treatment

Three-quarters (75%) of units reported that they record the smoking status of their patients, but only 47% had a policy for treatment of tobacco addiction, and only 37% prescribed pharmacological treatment for this.

Table 2 shows the availability of treatments and whether or not these services were available locally. Our audit also showed that the number of sites having on-site access to pulmonary rehabilitation (61% in 2019, 67% in 2017, 81% in 2014) has decreased over the last 5 years. This trend should be interpreted with caution as our survey design now highlights the suitability of pulmonary rehabilitation services for lung cancer patients specifically; whereas in 2017 we asked simply whether pulmonary rehabilitation services were available, in 2019 we asked whether such services suitable for lung cancer patients were available.

**Table 2** Availability of treatments

Modality	On site	Off site	Unavailable
Palliative/supportive care	96%	4%	
Dietician	90%	1%	9%
Biological therapy	83%	17%	
Immunotherapy	81%	19%	
Pulmonary rehabilitation (for lung cancer)	61%	39%	
Stereotactic radiotherapy to lung primary	21%	79%	
VATS lobectomy	20%	79%	1%
Thoracic surgery	19%	81%	
Stereotactic radiotherapy to cerebral metastases	16%	84%	

VATS = video-assisted thoracic surgery

A total of 28 thoracic surgical units (27 in England and one in Wales) provided additional information about their services. The median number of thoracic surgeons in each unit was three, and 75% of units were staffed with at least three whole time equivalent (WTE) staff. There was an average of 8.8 (median 6) theatre sessions per week and an average of 4.7 (median 4) high-dependency unit (HDU) beds at each unit. Units described having problems with patient flow due to inadequate HDU beds frequently (15%), sometimes (35%), rarely (42%) or never (8%).

## Staffing

Although it is difficult to accurately measure staffing levels and the percentage of an individual's job devoted specifically to lung cancer work, some useful data was obtained. Based on some ambiguity in the questions about staffing in the 2017 audit, these questions were refined to be more specific and to align more closely to the intentions of the commissioning guidance. As a result, where staffing levels appear to have changed from 2017, this may in large part be a reflection of a more accurate analysis rather than an absolute improvement or deterioration. Table 3 demonstrates the median staffing levels, and the range of number of staff per unit of trusts / health boards that completed the survey.

**Table 3** Staffing levels

Staff member	Median number of staff per unit	Range of number of staff per unit	Median of filled WTE posts	Range of filled WTE posts
Chest physicians	4	0–14	3.6	0–8.9
Clinical oncologists	1	0–27	1	0–25.5
Medical oncologists	1	0–18	1	0–17.3
Thoracic radiologists	2	0–14	2	0–7
Histopathologists	3	0–21	-	-

WTE = whole time equivalent

Table 4 demonstrates staffing levels against commissioning guidance (where complete data is available), comparing the results from this audit with the last audit in 2017. Overall, only 5% (8% in 2017) of sites had adequate levels of specialist staffing across all of respiratory medicine, medical/clinical oncology, radiology and specialist nursing.

**Table 4** Staffing levels in 2019 and 2017 against commissioning guidance

Metric	2019 % (n=94)	2017 % (n=129)
10 PAs respiratory physician for direct clinical care per 200 new diagnoses per year	16	61
Radiologist with at least one-third of job plan devoted to lung cancer	65	83
Medical oncologist with at least one-third of job plan devoted to lung cancer	74	60
Clinical oncologist with at least one-third of job plan devoted to lung cancer	83	70
One WTE LCNS per 80 new diagnoses per year	32	19

n = number of units that provided data

LCNS = lung cancer nurse specialist; PAs = programmed activities; WTE = whole time equivalent

Note: the variance in results observed between 2017 and 2019 may be explained by a change in survey design, highlighting that:

- In 2017 the survey asked for the number of WTE respiratory physicians who were involved in lung cancer care, whereas in 2019, the survey asked for the total number of direct clinical care sessions provided by these physicians (to enable closer alignment with the commissioning guidance). The result for 2019 (16%) reflects a much more accurate evaluation of respiratory physician staffing levels, while any deterioration in staffing levels should not be concluded.
- Similarly, for the radiologist and oncologist measures, in 2017, the survey only gathered an indirect calculation of staffing levels that may have lacked specificity and accuracy, which was addressed in the 2019 survey design, evaluating the proportion of staff with at least one-third of their job plan devoted to lung cancer.
- There was no change to the survey design for evaluating LCNS staffing levels.

The lung cancer clinical lead had protected time in their job plan for the role in only 62% of units, and where time was allocated, it was generally up to 1 PA. Only 67% of units had an MDT member with responsibility for data quality, and of these only 18% had time in their job plan for this role. Despite this, 65% of units carried out validation of their data COSD (Cancer Services and Outcomes Dataset) submissions and 72% accessed the CancerStats website to monitor their data quality.

### National key performance indicators

Fig 4 shows the percentage of sites that met individual key indicators from national commissioning guidance (where complete data was available) split into three groups in the 2019 audit and compared with the 2017 audit. The number of recommendations met by each site varied from 1–11.

Out of the sites that submitted complete data (n=94), 31% (29% in 2017) of sites complied with 1–4 of the metrics, 44% (50% in 2017) met 5–7 and 26% (21% in 2017) met 8–11 of the recommendations.

**Fig 4.** Percentage of sites in the third (2019) organisational audit compared with the second (2017) that met key indicators from national commissioning guidance

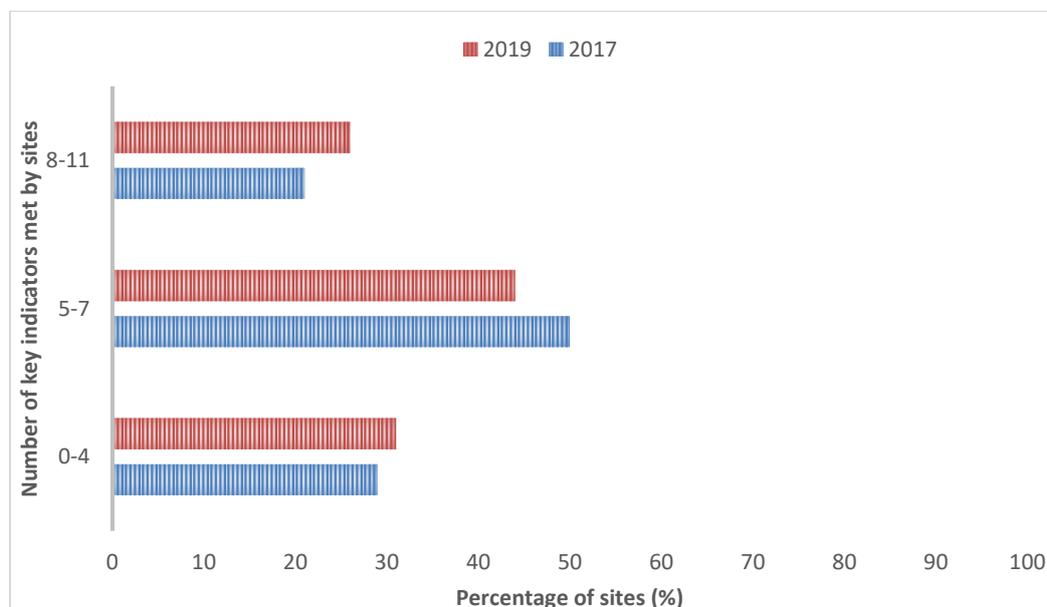


Table 5 reports the national performance against each individual key indicator where complete data is available (n=94).

**Table 5** National performance against each individual key indicator from national commissioning guidance

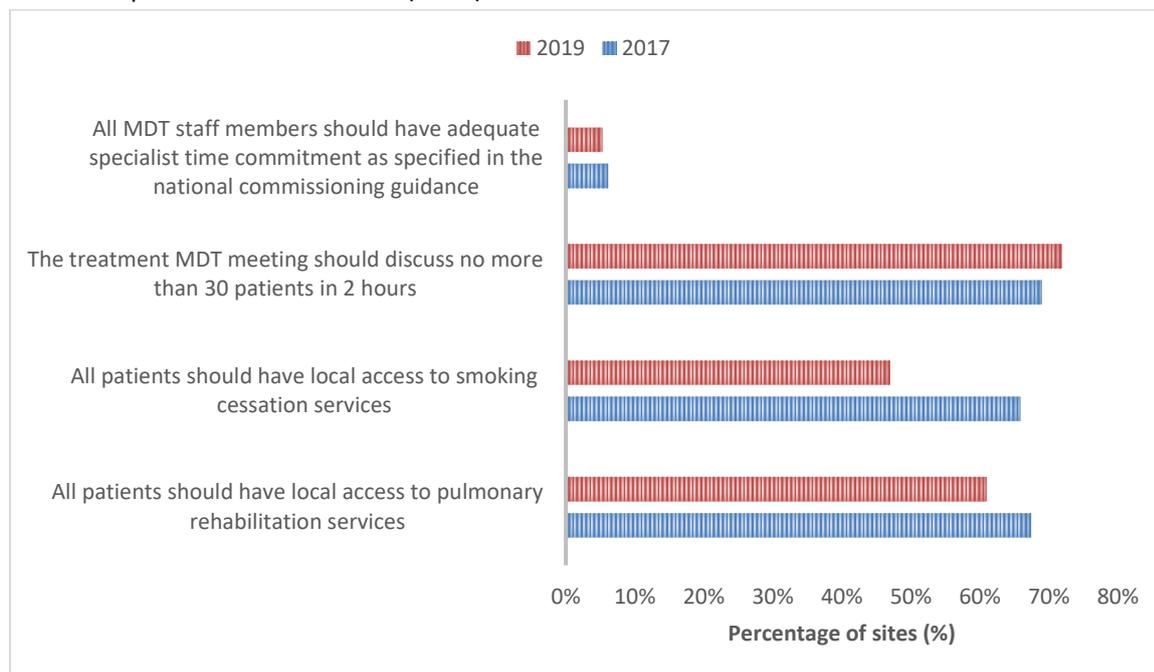
Indicator	%
Clinical oncologist with at least one-third of their job plan devoted to lung cancer	83
On-site EBUS	77
Medical oncologist with at least one-third of their job plan devoted to lung cancer	74
Radiologist with at least one-third of their job plan devoted to lung cancer	65
On-site access to molecular testing	63
On-site thoracoscopy	60
Separate diagnostic planning MDT meetings	57
One WTE LCNS per 80 new diagnoses per year	32
On-site PET scan	30
On-site cardiopulmonary exercise testing	30
One whole time equivalent (10PA) respiratory physician for direct clinical care per 200 new diagnoses per year	16

EBUS = endobronchial ultrasound; LCNS = lung cancer nurse specialist; MDT = multidisciplinary team; PET = positron emission tomography; WTE = whole time equivalent

Compliance with recommendations showed national variation with 83% of sites reporting a clinical oncologist with at least one-third of their job plan devoted to lung cancer, to just 16% of units meeting the recommendation of having 10 PAs of respiratory physician for direct clinical care per 200 new diagnoses per year.

Looking specifically at the four recommendations made in the 2017 organisational audit, Fig 5 shows the percentage of sites that fulfilled the 2017 recommendations in the third organisational audit compared with the second.

**Fig 5** Percentage of sites that fulfil the 2017 recommendations in the third (2019) organisational audit compared with the second (2017)



MDT = multidisciplinary team

Although the above comparison is provided these results must be interpreted with caution owing to differences in the number of participating organisations across the two audit periods and changes in survey design (in 2017 the survey specifically asked for information on ‘whether there was an on-site, off-site or no available smoking cessation service available’ whereas in 2019 the survey asked for information on ‘the availability of an agreed tobacco addiction treatment policy’. See also page 10 regarding pulmonary rehabilitation services).

## Conclusions and recommendations

These data provide a snapshot of lung cancer services in England and Wales. Since the first organisational audit, improvements in on-site access to key diagnostics such as molecular testing (19% of sites in 2017 and 29% in 2019) and thoracoscopy (53% in 2017 and 57% in 2019) have been shown. However, in this report we see that variability remains in the provision of services and staff shown by the spread in number of recommendations met by individual sites.

The report highlights the following deficiencies in the national organisation of lung cancer services:

- Only 5% of sites had adequate levels of staffing in all of five key areas.
- In two-thirds of sites, one WTE LCNS had a workload of over 80 new diagnoses per year.
- Approximately one-third of sites did not meet the 3-day standard for tumour subtyping.
- Approximately two-thirds of sites did not meet the 10-day standard for obtaining a molecular marker status.
- Many sites relied on services at other organisations which can lead to fragmentation and delay if not managed in a coordinated and equitable way.

While it is acknowledged that defining workload accurately is difficult, these findings are key to understanding variation seen in patient outcomes shown in the annual NLCA report

([www.rcplondon.ac.uk/projects/outputs/nlca-annual-report-2018](http://www.rcplondon.ac.uk/projects/outputs/nlca-annual-report-2018)) and highlights the challenge in nationally adopting the National Optimal Lung Cancer Pathway (NOLCP) and the NSGC. Locally, we urge teams to use site level results from this audit to advocate for the recommended service provision that has been shown to improve outcomes for people with lung cancer. However this report also calls for national action to address these deficiencies in staffing provision. This is particularly crucial given the likelihood of a national screening programme for lung cancer being implemented.

While there is scope to improve services at a local level, it is likely that regional and national coordination and action will need to be undertaken, including investment in staffing and infrastructure, to bring services in line with recommendations and ambitions.

Based on the findings of the 2019 organisational audit we recommended the following critical actions:

- A gap analysis of local staffing levels should be undertaken by cancer MDTs against national service guidance (NOLCP and the NSGC). The results of the gap analysis should be used by cancer alliances and commissioners to inform and support local and regional action planning to improve staffing.
- Lung cancer teams who do not meet targets for pathological subtyping and molecular testing should work with their pathology providers to process map these pathways in order to improve performance.
- Where diagnostic/staging investigations and treatments are not available on-site at the local hospital, cancer alliances should work with providers to ensure that all patients in the region are achieving equitable and timely access.

Furthermore:

- Lung cancer clinical leads should have protected time in their job plans to allow them to carry out the role effectively.
- Every lung cancer team should have a MDT member with responsibility for data quality with protected time in their job plan to allow them to carry out the role effectively.
- Lung cancer teams should ensure that their patient-facing staff are all trained in delivering 'very brief advice' on smoking cessation, and that members of the team are trained to deliver treatment for tobacco addiction. Work with local smoking cessation services should also be undertaken to develop pathways suitable for these patients.
- Lung cancer teams should work with local pulmonary rehabilitation services to develop pathways suitable for these patients.

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## Document purpose

Document purpose	To disseminate results on the findings from the National Lung Cancer Audit organisational audit 2019, relating to the availability of treatment and diagnostic modalities and lung cancer specialist staffing levels across England and Wales.
Title	National Lung Cancer Audit. Organisational audit report 2019
Author	Royal College of Physicians, Care Quality Improvement Department
Publication date	January 2020
Target audience	NHS staff in lung cancer multidisciplinary teams; hospital managers and chief executives; commissioners; lung cancer researchers; lung cancer patients, their families and their carers.
Description	This is the National Lung Cancer Audit's third organisational audit report. It publishes national level findings on the organisation of lung cancer services in England and Wales. It reflects the organisation of lung cancer services as of June 2019. units can use this report to benchmark their performance against national level findings.
Related publications	National Lung Cancer Audit report 2017 (for the audit period 2016) National Lung Cancer Audit report 2014 (for the audit period 2013)
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## Acknowledgements

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This year, the organisational questionnaire was designed in collaboration with the Getting It Right First Time (GIRFT) initiative, a national programme designed to improve medical care within the NHS by reducing unwarranted variations. The NLCA have shared trust-level results of the 2019 organisational audit with the GIRFT team, working together towards better care for patients with lung cancer.



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