NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE
CENTRE FOR CLINICAL PRACTICE
QUALITY STANDARDS PROGRAMME

Quality Standards Scoping Workshop –
Lung Cancer and Hip Fracture Topic Expert Groups

Minutes of the Quality Standards scoping meeting held at 10.30 on 3rd June 2011 at the NICE Manchester office, Level 1A, City Tower, Piccadilly Plaza, Manchester M1 4BD.

Welcome, introductions and plan for the day

Beth Shaw (BS), David Baldwin (DB) and Cameron Swift (CS) welcomed all members of the Topic Expert Group (TEG). BS asked those present to introduce themselves before reviewing the agenda and timescales for the meeting. She explained that the purpose of the meeting was to describe the process of developing NICE quality standards and to scope the topic using the care pathway.

Quality Standards process overview led by Beth Shaw

BS presented the group with an overview of the process for developing NICE quality standards, drawing from the Quality Standards Process Guide. She highlighted the key functions involved in the process including the TEGs and the National Quality Board.

BS explained how NICE defines a quality standard and how they are derived from the best available evidence, such as NICE guidance or other NHS Evidence accredited sources.

BS described the purpose of the quality standards, including how they are used at present and their potential uses in the future, particularly in relation to the NHS White Paper *Equity and Excellence: Liberating the NHS* and the Health and Social Care Bill. BS also explained the relationship between the Quality Standards Programme and the Quality and Outcomes Framework.

The groups discussed the use of the term 'aspirational' to describe a quality standard and suggested that this was not appropriate as it implies the standard is not achievable. Rachel Neary (RN) confirmed that the quality statements should describe high quality care but should also be achievable.

The group queried the link between NICE quality standards and other quality initiatives, such as the Cancer Peer Review. RN confirmed that a preamble would be added to all cancer quality standards to make it clear that the standard should be considered alongside these other documents. The group commented however that the quality standard should go further than peer review as this can often be seen as too process driven.

BS outlined the role of the TEG, including drafting quality statements and measures, considering cost and equality impacts of standards and refining draft standards following the consultation period. She also highlighted that members represent themselves and not any particular organisation.

BS also described the consultation and publication processes.

Quality Standards example led by Carl Prescott/Anna Brett

Carl Prescott (CP) outlined the process for developing a quality standard from the original guideline recommendations to the draft and then the finalised quality standard. He said the statements should be specific and concise and reflect high quality patient care. He also added that each statement should have a measurable element. CP showed the TEG how the quality standards look and how they can be accessed on the NICE website.

Anna Brett (AB) gave some additional information on the process for developing a quality standard, using the quality standard on dementia as an example. She outlined the scope of this quality standard, the policy context and key development sources and described the use of the areas of care map.

Quality Standards methodology led by Beth Shaw

BS outlined the draft methodology for the development of NICE quality standards. She said the statements generally relate to key priorities for implementation or areas likely to have the biggest impact on patient care and patient outcomes.

BS also highlighted some important issues for consideration when developing the quality standard, including clinical cost and effectiveness, patient safety, patient experience and equality.

The group asked whether there was any data on the use of quality standards which the group could see before beginning development. RN confirmed that, as the quality standard process was relatively new, there was little data available on the use of quality standards. She did however highlight a piece of work currently being undertaken by one of the NICE scholars on the use of the stroke quality standard and agreed to keep the group informed of this work.

Business Items

- **Declarations of interest**
  RN gave an overview of the declaration of interest policy and emphasised that any interests from the last 12 months should be declared.

The TEG was informed that any strong, prejudicial statements from members should be discussed with BS, RN or with the relevant appointed chair.

- **Equality impact assessment**
  RN gave an overview of the equality impact assessment in relation to the quality standards. She confirmed that the NICE approach is to check that decisions made in the TEG meetings meet the equality impact assessment criteria.

Next steps

BS gave an overview of the timelines for the development of the lung cancer and hip fracture quality standards.

Attendees

Lung Cancer Topic Expert Group

Dr David Baldwin, Consultant Respiratory Physician

Dr Abebaw Mengistu Yohannes, Reader in Physiotherapy

Mr Sion Barnard, Consultant Thoracic Surgeon

Dr Robert Rintoul, Consultant Respiratory Physician

Dr Andrew Wilcock, Clinical Reader in Palliative Medicine and Medical Oncology

Mrs Dana Knoyle, Lung Cancer Clinical Nurse Specialist

Mr Bob Park, Cancer Network Director

Dr Paul Cane, Consultant Histopathologist

Dr Jesme Fox, Medical Director

Mr Thomas Haswell, Patient Member

Mr Barry Attwood, Patient/Carer Member

Dr Ian Manifold, NCAT Representative

Dr Andrew Champion, Observer

Apologies

Dr Richard Neal, Senior Lecturer in General Practice

Dr Michael Peake, Consultant/Professor in Respiratory Medicine

Dr Jeremy Braybrooke, Consultant Medical Oncologist

Dr Mia Schmidt-Hansen, Researcher

Mr Matthew Hatton, Consultant Clinical Oncologist

Hip Fracture Topic Expert Group

Professor Cameron Swift, Professor of Health Care of the Elderly

Mr Tony Field, Patient Member

Mrs Karen Hertz, Advanced Nurse Practitioner

Professor. Opinder Sahota, Professor in Orthogeriatric Medicine/Consultant Physician

Mrs Heather Towndrow, Integrated Schemes Manager

Mr Martin Wiese, Consultant in Emergency Medicine

Dr Tessa Lewis, General Practitioner

Apologies

Mr Bob Handley, Consultant Trauma and Orthopaedic Surgeon

NICE staff

Beth Shaw, Senior Technical Advisor

Carl Prescott, Quality Standards Technical Analyst

Anna Brett, Quality Standards Technical Analyst

Rachel Neary, Interim Quality Standards Programme Manager

Andy McAllister, Quality Standards Programme Manager

Ester Clifford, Quality Systems Project Manager

Helen Crosbie, Interim Quality Systems Coordinator

Lucy Spiller, Quality Standards Coordinator

Clifford Middleton, Guidelines Commissioning Manager (Observing)

Claire Turner, Guidelines Commissioning Manager (Observing)

Stephanie Birtles, Accreditation Technical Analyst (Observing)

Nick Staples, Project Manager (Observing)

Apologies

Mark Baker, Clinical Advisor

Edgar Masanga, Costing Analyst

Paula Prior, Costing Analyst

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Quality Standard Topic: Lung Cancer

Output: Working notes of induction breakout session

The following areas were discussed as part of the breakout session in order to establish and agree the scope of the quality standard for lung cancer.

Evidence sources

The group agreed the sources of data outlined in the topic overview to be used in the development of the quality standard. The group agreed that the diagnosis and treatment of lung cancer, clinical guideline 121, should be the primary evidence source, including those sections not updated since 2005.

Other development sources

The group agreed that the following sources could also be considered in the quality standard depending on NHS Evidence accreditation:

- Liverpool Reviews and Implementation Group's HTA of chemotherapy treatments. (This is currently draft).
- NICE Service Guidance Improving Supportive and Palliative Care for Adults with Cancer
- Royal College of Pathologists' tissue biology update (once published)
- Improving outcomes: a strategy for cancer (2011)
- Improving Outcomes Guidance (1998)
- Most recent National Lung Cancer Audit – now available
- Referral for suspected cancer clinical guideline 27

Areas of care

The group considered the areas of care diagram, adapted from the areas identified in clinical guideline 121 and DB led the group through discussion of the key recommendations from the guideline, and agreed that the draft standard will consider the following areas of care:

1. Early diagnosis - considering incidental chest x-ray findings, presentation in primary and secondary care, the importance of public awareness.
2. Diagnostic and staging – focusing on 'correct test at the correct time' and the need to reduce the number of tests a patient needs whilst avoiding the unintended consequence of patients not being staged properly. Timing of PET CT scan could be considered.
3. Efficacy of tests - to include all staging tests. Consider audit of particular tests such as EBUS TBNA to ensure they're being done effectively.
4. Adequacy of samples – to enable prognostic assessment and classification, targeting those doing EBUS. Consider clinical lines of enquiry measuring rates of histological confirmation.
5. Multidisciplinary team/ access to specialists
6. Clinical Nurse Specialist – considering availability of and access to the CNS. Though this is potentially difficult to measure the group agreed this was a key area of care for lung cancer.
7. Treatment for small cell lung cancer (SCLC) – focusing on the key recommendation that patients have access to thoracic oncologist within 1 week. Agreed important given that 20% of SCLC patients die before treatment.
8. Surgery – access to surgery, covering all patients, not just those who are borderline fit. Agreed that resection rates are the key route improving health outcomes in this area.
9. Radiotherapy – focusing on its availability to lung cancer patients rather than the quality assurance of the technique, as that issue was not specific to lung cancer. Statement/area should also focus on patients being properly assessed for these treatment options and being referred to MDTs.
10. Chemotherapy for non small cell lung cancer (NSCLC) – group agreed that patient numbers are too small to include a specific area on chemotherapy for SCLC patients.

11. Follow up – emphasising regular follow-up rather than an ‘as required’ appointment.

12. Smoking cessation – secondary prevention. Group agreed that there is evidence to show that patients who give up smoking when they have lung cancer will live longer – regardless of the type of treatment they are receiving, although effect on survival is uncertain. It was felt that smoking cessation was a topic dealt with elsewhere – ie. public health guidance, but that this did not necessarily cover secondary prevention. There was discussion over whether this could be measured, and what impact it might have, but agreement that it was important to include.

13. Palliative care – early referral. Focusing on a holistic needs assessment and ensuring that the palliative care relevant to all areas of care and could cover psychological support. Agreed that patients should have access to palliative care throughout the entire pathway as most lung cancer treatment is palliative, so more than one aspect of palliative care should be covered by the quality standard.

14. Palliative care – endobronchial therapy. Focusing on access to an endobronchial treatment centre, although it was acknowledged that this might be difficult to include as a statement because a network may have geographically convenient access to another network’s centre. Agreed every patient should have access to endobronchial therapy.

Topic expert group membership

The group considered the membership of the topic expert group and agreed that a radiologist should be invited to join the group, as this post had not been successfully recruited via NICE’s website. The group also agreed that a commissioner needed to be recruited as recruitment for this post had also been unsuccessful.

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Quality Standard Topic: Hip Fracture
Output: Working notes of induction breakout session

CS explained that Tim Chesser (TC) and Bob Handley (RH), the surgical members of the group, were unable to attend the workshop due to scheduling conflicts. CS advised the group that for this reason, some surgical topics may not be discussed in full at this meeting but confirmed that the surgical members would be consulted after the meeting.

The following areas were discussed as part of the breakout session in order to establish and agree the scope of the quality standard for hip fracture.

Evidence sources

The group agreed the sources of data outlined in the topic overview to be used in the development of the quality standard. The group agreed that the following guidelines should be used as the primary evidence sources:

- The management of hip fracture in adults (NICE clinical guideline 124, due June 2011)
- Management of hip fracture in older people (Scottish Intercollegiate Guidelines Network [SIGN] clinical guideline 111, 2009)

Evidence sources, policy drivers and measures

The group agreed that the following sources could also be considered in the quality standard, depending on NHS Evidence accreditation:

- Clinical evidence for hip fracture – British Medical Journal, 2007 (2009 update)
- Best Practice Tariff for hip fracture
- Forthcoming guidance by British Geriatrics Society perioperative care for hip fracture patients
- The College of Emergency Medicine – standards of treatment for the treatment of suspected hip fracture
- Various relevant Cochrane Reviews

Areas of care

The group considered the areas of care diagram, adapted from the areas identified in the 'evidence sources' section. CS and CP led the group through discussion of the key recommendations from the guidelines, and agreed that the draft standard will consider the following areas of care:

1. Transport to hospital – prompt transfer of patients with a suspected hip fracture to hospital with adequate pain relief. Although the group acknowledged that ambulance targets would need to be considered. The group also acknowledged that the clinical recommendation on the prompt transfer of patients was not evidence based, however felt that pain management during transit was an important issue to consider for people with hip fracture
2. Orthogeriatric assessment – patients with suspected hip fracture should receive an acute hospital based Hip Fracture Programme including orthogeriatric assessment and appropriate orthogeriatric management from the time of admission onwards with assessment and management of comorbidities to prevent delay to surgery. The Best Practice Tariff should be referred to for potential timeframes.
3. Imaging – the group felt this was an important, measurable aspect and was also highlighted by the National Patient Safety Agency (NPSA) as a potential patient safety issue. The group commented that the four hour wait target had been removed since the guideline was developed and felt this could potentially lead to slower transfer times though A&E. CP agreed to see whether any recommendations have been made by any other NHS Evidence accredited sources regarding timely first x-

ray. Imaging options for occult hip fracture are, however, an issue for only 2-5% of patients.

4. Assessment and management of pain – patients with suspected hip fracture should receive timely, appropriate assessment and management of their pain at admission and regularly throughout their stay. This statement could be measured by auditing recording of the assessment and management of pain on the patient's observation chart. Time to first analgesic dose was also suggested as a potential measure. The group felt this statement should be overarching across the areas of care rather than included within 'hospital management' and highlighted it as an important issue for patient safety and experience. Also Paracetamol should be used as a first line treatment rather than non steroidal anti inflammatory drugs.
5. Timing to surgery – a) the timing of surgery, on the day of or day after admission b) the use of planned trauma lists and ensuring senior supervision of a doctor performing the surgery. The group identified this as a fundamental component of CG124 and therefore of the quality standard. Significant variation is recognised throughout the country.
6. Surgical procedures – a) patients with a displaced intracapsular fracture receiving a replacement arthroplasty with the use of cement b) offering total hip replacement to those fitting the criteria included within the NICE clinical guideline c) the use of extramedullary implants as these are shown to be highly cost effective. .
7. Physiotherapy and mobilisation – patients should be given a physiotherapy assessment on the day of surgery and should be mobilised every day thereafter. There should also be regular review of this. The group acknowledged this will have a considerable impact on service providers as they will have to offer a 7 day service but felt that this was important to drive up the quality of care in this area.
8. Multidisciplinary rehabilitation team (MDT) – the existence of an integrated acute hospital-based multidisciplinary rehabilitation team meeting at least once per week. The National Hip Fracture Database Audit measures existence of an MDT and showed that the majority of hospitals will transfer patients to other places for rehabilitation, including ill-defined models of "intermediate care". This is not cost effective. The rehabilitation should be done primarily at the acute hospital, structured around a Hip Fracture Programme.
9. Early supported discharge – the availability of an integrated, hip fracture programme led early supported discharge facility. The group acknowledged the need to be careful with terminology as some patients associate 'early' with 'premature'. They also commented that

this statement may be difficult to measure however acknowledged that this was an important patient experience and outcome issue.

10. Delirium and dementia – hip fracture patients should be assessed for delirium and dementia in accordance with NICE guidance. Dementia may be included under the area of care under orthogeriatic assessment and management of comorbidities.
11. Secondary prevention – Falls risk assessment – patients must be assessed for their falls risk in accordance with NICE clinical guideline CG21. The group felt this was an important area for inclusion as the uptake of CG21 is variable. Patients should then be referred to and assessed by a falls prevention service within four weeks of discharge. Also consider a falls rehabilitation programme and appropriate interventions.
12. Secondary prevention – Bone health service – there should be evidence of fracture risk assessment and management in accordance with TAG161.
13. Information for patients – patients should receive appropriate information, both written and verbal, including information about the procedures they may receive.
14. Palliative care – patients with a palliative care condition should be appropriately identified and an individualised care plan should be developed by the MDT, in conjunction with the palliative care team.

The group also considered including the following areas of care but felt these either should not be considered by the quality standard or required further investigation:

1. VTE prophylaxis – it was acknowledged that there was an additional quality standard on VTE prevention but this did not specifically cover VTE after surgery. It was also acknowledged that this was a controversial area and had not been within the scope of CG124. The group therefore felt they needed input from the surgical members before they could make a decision on inclusion of VTE prophylaxis.
2. Surgical site infection – the group felt that for the same reasons as in (1) they needed input from the surgical members before they could make a decision on inclusion of surgical site infection.
3. Choice of anaesthesia – no evidence to support this as a key area for consideration so not to be considered during development of the quality standard.

4. Nutrition support and pressures sores – likely to be addressed by individual quality standards so not to be considered during development of the hip fracture quality standard. These should however be referred to as important in the pre-amble.
5. Nerve blocks – not considered to be a key area for consideration.

Equality issues

The group highlighted patients in nursing/residential homes as an equality issue. They emphasised the need to ensure they are included in the Hip Fracture Programme but were unsure how they could measure this.

Topic expert group membership

The group considered the membership of the topic expert group and agreed that four additional members should be invited to join the group, as these posts were not successfully recruited via NICE's website. The additional members required were identified as:

1. An additional lay member.
2. A commissioner.
3. A consultant anaesthetist.
4. A social care representative.