Quality Standards Lung Cancer Topic Expert Group

Minutes of the TEG3 meeting held on 16th January 2012 at the NICE Manchester office

Attendees	**Topic Expert Group Members** David Baldwin (DB) [Chair], Abebaw Mengistu Yohannes (AMY), Sion Barnard (SB), Matthew Hatton (MH), Andrew Wilcock (AW), Richard Neal (RN), Michael Peake (MP), Dana Knoyle (DK), Bob Park (BP), Paul Cane (PC), Thomas Haswell (TH), Jesme Fox (JF), Barry Attwood (BA), Mia Schmidt-Hansen (MSH), Rorie Jefferies (RJ), Ian Manifold (IM), Fergus Gleeson (FG), Azim Lakhani (AL) **NICE Staff** Anna Brett (AB), Terence Lacey (TL), Mark Baker (MB), Andy McAllister (AMA), Lucy Spiller (LS) [Minutes], Jennifer Hopes (JH), David Tyldesley (DT) **Observers** Kate Moring (NICE), Nicola Greenway (NICE), Tony Smith (NICE)
Apologies	**Topic Expert Group Members** Robert Rintoul, Jeremy Braybrooke

Agenda item	Discussions and decisions	Actions
1. Introductions and apologies	DB welcomed the attendees and reviewed the agenda for the day. DB informed the group that Robert Rintoul and Jeremy Braybrooke were unable to attend the meeting.	
2. Declarations of interest	DB asked the group whether they had any new interests to declare since the last meeting. BP advised the group that he had been working with the Hamad Medical Corporation but said the work undertaken was about not lung cancer specific. DB did not feel any action was required as a result of this. TH advised the group that he had received honorariums and travel expenses from the pharmaceutical sector. DB did not feel any action was required as a result of this. MP advised the group that he had given some lectures relating to lung cancer. DB did not feel any action was required as a result of this. No other group members had any additional interests to declare.	
3. Review of progress so far and objectives of the day	TL reviewed the progress made on the quality standard (QS) so far. He advised the group that the main objectives of the day were to discuss the results of the consultation and agree up to 15 quality statements for progression into the final QS. He told the group that the final QS will include all the information the group considers important but advised them that the final version may look different due to the NICE editorial process. He also confirmed that the group will have the opportunity to see the final version of the QS before publication.	
4. Support for commissioners and others using the quality standard	DT outlined the role of the costing and commissioning team and advised the group that he and JH will develop a support document for commissioners and other users to accompany the QS. He told the group that the purpose of this document is to help commissioners and service providers consider the commissioning implications and potential resource impact of using the QS. DT advised the group that they may need to provide input during its development. He also told them that they will have the opportunity to comment on the document during a 2 week consultation in February. He asked the group to contact himself or JH if they have any questions.	
5. Presentation and discussion of consultation feedback	AB gave a brief overview of the consultation process, focussing on the positive themes and the areas for consideration. She said that the positive comments generally focussed around these areas: • The QS is welcomed and stakeholders believe it can make a difference to patient outcomes.	

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	• The QS is comprehensive and encompasses the vast majority of patient care. • The QS recognises the importance of teamwork. The areas which require further consideration were highlighted as: • The burden on lung cancer teams to collect data. • Further clarity required around some measurements. • The link to the end of life care QS. AB advised the group that they would consider statement-specific comments received throughout the day.	
6. Presentation, discussion and agreement of final statements	**Draft Quality Statement 1:** People are made aware of the symptoms and signs of lung cancer through coordinated public awareness campaigns that result in early presentation. AB advised the group that there was general stakeholder support for this statement and its importance. Following stakeholder comments the group considered broadening this statement to include GP awareness of the symptoms and signs of lung cancer but did not feel this was appropriate. The group felt it was important to include a definition of what is meant by 'early presentation'. The group agreed to progress the statement without altering the wording: **Quality statement 1:** People are made aware of the symptoms and signs of lung cancer through coordinated public awareness campaigns that result in early presentation.	Include a definition of 'early presentation'. Progress the statement as it stands.
	Draft Quality Statement 2: People presenting with symptoms suggestive of lung cancer are referred urgently for a chest X-ray or directly to a chest physician who is a core member of the lung cancer multidisciplinary team. **Draft Quality Statement 3:** People with a chest X-ray result suggestive of lung cancer have a copy of the radiologist's report sent to and followed up by the lung cancer multidisciplinary team. Following stakeholder comments the group agreed to merge draft statements 2 and 3 into a statement for progression.	Merge draft statements 2

Agenda item	Discussions and decisions	Actions
		and 3.
	The group felt it was important to include 'from any source' in the statement. This was also an area for inclusion which was highlighted by stakeholders during the consultation.	Include 'from any source' in the statement.
	The group agreed to progress the statement with the following revised wording: **Revised Quality Statement 2/3:** People presenting with symptoms suggestive of lung cancer are referred urgently for a chest X-ray or directly to a chest physician who is a core member of the lung cancer multidisciplinary team. All chest X-ray reports (from any source) suggestive of lung cancer are copied to the lung cancer multidisciplinary team.	Progress the statement with the revised wording.
	Draft Quality Statement 4: People with known or suspected lung cancer are provided with opportunities to discuss tests and the risks and benefits of treatment options in a private environment, and are offered information that supports them to make informed choices. Following stakeholder comments the group considered merging draft statements 4 and 5 but did not feel this was possible. As suggested by stakeholders they also considered including clarity around the nature of the information given to patients, but did not feel this was necessary.	
	Following stakeholder comments around the importance of information for carers the group agreed to include 'and (where agreed) their carers'.	Include 'and (where agreed) their carers' in the statement.
	The group agreed to include 'with a member of the lung cancer multidisciplinary team'.	Include 'with a member of the lung cancer multidisciplinary team' in the statement.
	The group agreed to progress the statement with the following revised wording: **Revised Quality Statement 4 (now Quality Statement 3):** People with known or suspected lung cancer and (where agreed) their carers, are provided with opportunities to discuss tests and the risks and benefits of treatment options in a private environment with a member of the lung cancer multidisciplinary team, and are offered information that supports them to make	Progress the statement with the revised wording.

Agenda item	Discussions and decisions	Actions
	informed choices.	
	Draft Quality Statement 5: People with known or suspected lung cancer have access to a lung cancer clinical nurse specialist who they can contact between scheduled hospital visits for continuing support, and people with lung cancer are subsequently offered the option of protocol-driven follow-up. The group agreed to specify that the lung cancer clinical nurse specialist should be 'named'. The group agreed to remove 'for continuing support´. Following stakeholder suggestions the group agreed to move the follow-up section to draft statement 17 (now Quality Statement 14). The group agreed to progress the statement with the following revised wording: **Revised Quality Statement 5 (now Quality Statement 4):** 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.	Add 'named' into the statement. Remove 'for continuing support´ from the statement. Move 'people with lung cancer are subsequently offered the option of protocol-driven follow-up.' to draft statement 17. Progress the statement with the revised wording.
	Draft Quality Statement 6: People with lung cancer are offered a holistic needs assessment at each key stage of care, and are offered prompt referral to specialist services when necessary. AB advised the group that during consultation stakeholders were asked whether a 2 week timeframe was achievable and therefore should be included in the statement. She told the group that stakeholders had responded positively, agreeing that a two week timeframe was acceptable as long as there is flexibility to allow for patient choice. The group therefore	Change the wording to 'and receive specialist

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	agreed to change 'and are offered prompt referral to specialist services when necessary' to 'and receive specialist services (where agreed) within 2 weeks of any referral.' Following stakeholder comments the group considered including a reference to carers and changing 'stage of care' to 'stage of care, including on the emergence of symptoms' but felt these additions would be superfluous. The group agreed to include 'to inform their care plan'. **Revised Quality Statement 6 (now Quality Statement 5):** People with lung cancer are offered a holistic needs assessment at each key stage of care to inform their care plan and receive specialist services (where agreed) within 2 weeks of any referral.	services (where agreed) within 2 weeks of any referral.' Include 'to inform their care plan' in the statement.
	Draft Quality Statement 7: People with known or suspected lung cancer who are current smokers are offered smoking cessation advice and therapies to help them stop smoking. AB advised the group that stakeholders had highlighted that smoking cessation was not appropriate for all patients and suggested that it could be addressed in another statement. The group discussed this feedback and decided that draft statement 7 will not be progressed.	Remove draft statement 7.
	Draft Quality Statement 8: People with suspected lung cancer following initial assessment and CT scan are offered diagnostic and staging tests that give the most information with the least risk, in accordance with NICE guidance. Following stakeholder comments the group considered merging draft statements 8, 9 and 10 however they did not feel this was possible. The group agreed to progress the statement without altering the wording: **Revised Quality Statement 8 (now Quality Statement 6):** People with suspected lung cancer following initial assessment and CT scan are offered diagnostic and staging tests that give the most information with the least risk, in accordance with NICE guidance.	Progress the statement as it stands.
	Draft Quality Statement 9: People with suspected lung cancer have comprehensive diagnostic and staging tests completed within 2 weeks of their first lung cancer clinic outpatient appointment or first contact with the lung cancer multidisciplinary team as an inpatient. Following stakeholder comments the group considered merging draft statements 9 and 10 however they did not feel this was possible.	

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	Following stakeholder comments on the appropriateness of the 2 week timeframe, the group agreed to change the wording of the second half of the statement to 'completed within 4 weeks of urgent referral from primary care and within 2 weeks of the initial CT scan and clinical assessment, except in complex cases.'	Change the wording to 'completed within 4 weeks of urgent referral from primary care and within 2 weeks of the initial CT scan and clinical assessment, except in complex cases.'
	The group agreed to include a definition of 'complex cases'.	Include a definition of 'complex cases'.
	The group agreed to progress the statement with the following revised wording: **Revised Quality Statement 9 (now Quality Statement 7):** People with suspected lung cancer have comprehensive diagnostic and staging tests completed within 4 weeks of urgent referral from primary care and within 2 weeks of the initial CT scan and clinical assessment, except in complex cases.	Progress the statement with the revised wording.
	Draft Quality Statement 10: People with suspected lung cancer have adequate tissue samples taken in a suitable form to provide a complete pathological diagnosis. Pathologists provide a complete diagnosis including tumour sub-typing and analysis of necessary predictive markers.	
	The group agreed to incorporate 'tumour typing' into the statement.	Incorporate 'tumour typing' into the statement
	The group discussed the wording of this statement and agreed the second half of the	Change the

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	statement should read 'including tumour typing and sub-typing, and analysis of necessary predictive markers.'	wording to 'including tumour typing and sub-typing, and analysis of necessary predictive markers.'
	The group agreed to progress the statement with the following revised wording: **Revised Quality Statement 10 (now Quality Statement 8):** People with suspected 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 necessary predictive markers.	Progress the statement with the revised wording.
	Draft Quality Statement 11: People with resectable lung cancer are offered an assessment of risk of a perioperative cardiac event, perioperative mortality and postoperative dyspnoea and mortality (including an increased risk for people who smoke). **Draft Quality Statement 13:** People with resectable lung cancer who are of borderline fitness are offered surgery or a second opinion on their fitness for surgery from the lung cancer multidisciplinary team including another thoracic surgeon.	
	Following stakeholder comments the group considered merging draft statements 11, 12 and 13 however they did not feel this was possible. After further discussion they agreed to merge draft statements 11 and 13 into a statement for progression. The group considered a suggestion by stakeholders that most multidisciplinary teams only have access to one thoracic surgeon, however they did not think they should alter the statement as a result of this.	Merge draft statements 11 and 13.
	The group agreed to progress the merged statement with the following revised wording: **Revised Quality Statement 11/13 (now Quality Statement 9):** People with resectable lung cancer undergo an assessment of risk in accordance with NICE guidance, and those who are of borderline fitness and not accepted for surgery are offered an MDT opinion on the option of non-surgical treatment with curative intent, and the choice of a second surgical opinion.	Progress the statement with the revised wording.

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	Draft Quality Statement 12: People with lung cancer being considered for multimodality treatment are assessed by a thoracic oncologist and a thoracic surgeon, and those with lung cancer potentially suitable for radiotherapy with curative intent are assessed by a clinical oncologist specialising in thoracic oncology. The group did not feel the wording of this statement fully reflected their intention as there was too much detail. As a result they decided to simplify the statement. The group highlighted that it would be necessary to include a definition of 'an MDT comprising all specialist core members'. The group agreed to move 'by a clinical oncologist specialising in thoracic oncology' to draft statement 14 (now Quality Statement 11). The group agreed to progress the statement with the following revised wording: **Revised Quality Statement 12 (now Quality Statement 10):** People with lung cancer receive multimodality assessment by an MDT comprising all specialist core members.	Change the wording of the statement to 'People with lung cancer receive multimodality assessment by an MDT comprising all specialist core members.' Include a definition of 'an MDT comprising all specialist core members'. Move 'by a clinical oncologist specialising in thoracic oncology' to draft statement 14. Progress the statement with the revised wording.
	Draft Quality Statement 14: People with lung cancer stage I-III and good performance status who are unable to undergo surgery are offered radiotherapy with curative intent, using	

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	planning and treatment techniques that optimise the dose to the tumour while minimising the risks of normal tissue damage. The group agreed to include 'by a clinical oncologist specialising in thoracic oncology'. The group agreed to change the title of the statement to 'optimal radiotherapy'. The group agreed to progress the statement with the following revised wording: **Revised Quality Statement 14 (now Quality Statement 11):** People with lung cancer stage I-III and good performance status who are unable to undergo surgery are offered radiotherapy with curative intent, by a clinical oncologist specialising in thoracic oncology, using planning and treatment techniques that optimise the dose to the tumour while minimising the risks of normal tissue damage.	Include 'by a clinical oncologist specialising in thoracic oncology' in the statement. Change the title of the statement to 'optimal radiotherapy'. Progress the statement with the revised wording.
	Draft Quality Statement 15: People with advanced stage IIIB or IV non-small-cell lung cancer and performance status 0-1 are offered systemic therapy, in accordance with NICE guidance, that is tailored to the histological type and sub-type of the tumour, and individual predictive factors. Following stakeholder comments on the benefits of systemic therapy in patients with poorer performance status the group agreed to change 'performance status 0-1' to 'eligible performance status'. The group felt it would be beneficial to include 'offered systemic therapy (first- and second-line)'.	Change 'performance status 0-1' to 'eligible performance status'. Include 'offered systemic therapy (first- and second-line)' in the

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		statement.
	The group agreed to change 'histological type and sub-type of the tumour' to 'pathological sub-type'.	Change 'histological type and sub-type of the tumour' to 'pathological sub-type'.
	The group agreed to progress the statement with the following revised wording: **Revised Quality Statement 15 (now Quality Statement 12):** People with advanced 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.	Progress the statement with the revised wording.
	Draft Quality Statement 16: People with small-cell lung cancer are assessed by a thoracic oncologist within 1 week of the decision to recommend treatment, and are offered chemotherapy and radiotherapy in accordance with NICE guidance. AB advised the group that the stakeholders emphasised the need for a timeframe in this statement as the ability of patients to access therapy is enhanced by rapid availability of specialist assessment.	
	The group agreed to change the wording to 'are clinically assessed'.	Change the wording to 'are clinically assessed'.
	The group agreed to change the second half of the statement to 'and appropriate treatment started within 1 week of the MDT recommendation.'	Change the wording to 'and appropriate treatment started within 1 week of the MDT recommendation.'
	The group agreed to progress the statement with the following revised wording:	

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	Revised Quality Statement 16 (now Quality Statement 13): People with small-cell lung cancer are clinically assessed by a thoracic oncologist and appropriate treatment started within 1 week of the MDT recommendation.	Progress the statement with the revised wording.
	Draft Quality Statement 17: People with lung cancer are offered a specialist follow-up appointment within 6 weeks of completing initial treatment(s) to discuss ongoing care, and offered regular specialist follow-up thereafter. Following stakeholder feedback regarding protocol-led follow up the group agreed to change the wording to 'and regular specialist follow-up thereafter, which can include protocol-led clinical nurse specialist follow-up.' The group agreed to change 'treatment(s)' to 'treatment'. The group felt it was important to include a definition of what is meant by 'regular'. The group agreed to progress the statement with the following revised wording: **Revised Quality Statement 17 (now Quality Statement 14):** 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.	Change the wording to 'and regular specialist follow-up thereafter, which can include protocol-led clinical nurse specialist follow-up.' Change 'treatment(s)' to 'treatment'. Include a definition of 'regular'. Progress the statement with the revised wording.
	Draft Quality Statement 18: People with lung cancer are monitored for endobronchial obstruction and offered prompt treatment when obstruction is identified. **Draft Quality Statement 19:** People with lung cancer have access to all appropriate palliative interventions and specialist palliative care delivered by expert clinicians and teams.	

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	Following discussion the group agreed to merge draft statements 18 and 19 into a statement for progression. They felt they should create a broader statement focussing on specialist palliative care and interventions. The group agreed to progress the merged statement with the following revised wording: **Revised Quality Statement 18/19 (now Quality Statement 15):** People with lung cancer have access to specialist palliative care and all appropriate palliative interventions including those for pleural effusion and large airway obstruction, delivered by expert clinicians and teams.	Merge draft statements 18 and 19. Progress the statement with the revised wording.
	AB advised the group that stakeholders had suggested the following additional areas for inclusion in the QS: • Key worker • MDT working • Support for carers • Access to clinical trials • Research for lung cancers with low survival rates • Accuracy of diagnosis • Family support and liaison with primary healthcare team • Open access CT scanning • Assessed for suitability for resection • Patients having opportunity to discuss adjuvant treatments with a medical or clinical oncologist The group discussed whether these additional statements should be included in the QS but felt they were either not appropriate for inclusion or were already covered by other existing statements.	
7. Equality impact assessment	The group considered the equality and diversity issues and highlighted that the lower socioeconomic groups may be disadvantaged in terms of awareness of information campaigns and access to radical treatments. However they emphasised that one of the desired outcomes of the QS is to prevent this. The group also highlighted that information for patients needs to be accessible and AB advised that this is addressed in the preamble.	
8. Next steps	AMA outlined the next steps, including key dates in the QS development process. He gave a brief outline of the endorsement process and told the group which organisations have expressed an interest in endorsing the QS to date.	
9. AOB	The TEG queried what will happen to the measures which were not discussed and/or	Discuss and

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	finalised during the meeting. DB told the group that the wording of the statements is most important at this stage and advised them that he will work with the NICE team on the measures over the next few weeks. A small group volunteered to discuss and agree the measures with DB and the NICE team in the coming weeks. DB thanked the group for their hard work and closed the meeting.	agree the measures outside the meeting.