Lifting the Goalposts for Standards of Care in Lung Cancer

LCA Lung Clinical Forum

25th March 2014
Welcome and LCA Lung Pathway Update

Dr Liz Sawicka, Chair - LCA Lung Pathway Group
Lung Forum – Informatics Update

Stephen Scott – LCA Senior Information Analyst
# Lung pathway group metrics

Last updated March 2014

## Log of updates

<table>
<thead>
<tr>
<th>1. Cancer Waiting Times</th>
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<tbody>
<tr>
<td>1.1 2 week wait GP urgent referral to 1st seen</td>
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<td>1.2 31 day decision to treat to 1st treatment</td>
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<tr>
<td>1.3 31 day subsequent surgery</td>
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<td>1.4 31 day subsequent drugs</td>
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<td>1.5 31 day subsequent radiotherapy</td>
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<td>1.6 62 day GP urgent referral to 1st treatment</td>
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<td>1.7 62 day consultant upgrade to 1st treatment – median waits</td>
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<td>1.8 62 day GP urgent referral to 1st treatment – distribution of week treated</td>
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<tr>
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</tr>
<tr>
<td>2.2 LUCADA data completeness</td>
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<td>2.3 Breakdown of staging completeness – LUCADA</td>
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<td>2.4 – Breakdown of stage – SCLC – LUCADA</td>
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<tr>
<td>2.6 – Number of patients diagnosed and demographic details</td>
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<table>
<thead>
<tr>
<th>3. Patient experience</th>
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<tbody>
<tr>
<td>3.1 NCPES 012 – Patient felt they were told sensitively they had cancer</td>
</tr>
<tr>
<td>3.2 NCPES 020 – Patient given name of the CNS in charge</td>
</tr>
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<td>3.3 NCPES 021 – Patient finds it easy to contact CNS</td>
</tr>
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<td>3.4 – NCPES 044 – Enough/nearly enough ward nurses on duty</td>
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<tr>
<td>3.5 NCPES 052 – Patient given clear written information about what should/should not do post discharge</td>
</tr>
<tr>
<td>3.6 NCPES 067 – Patient given right amount of information about condition and treatment</td>
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<tr>
<td>3.7 NCPES 070 – Patient’s rating of care ‘very good’/’excellent’</td>
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<th>4. Prevention/Early diagnosis</th>
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<tr>
<td>4.1 9% emergency presentation</td>
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<th>5. Diagnosis</th>
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<th>6. Treatment</th>
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<tbody>
<tr>
<td>6.1 Lung cancer resection rates – overall</td>
</tr>
<tr>
<td>6.2 Lung cancer resection rates – NSCLC – Total</td>
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<tr>
<td>6.3 Lung cancer resection rates – NSCLC – Stage 1 &amp; 2</td>
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<th>7. Peer review</th>
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<tr>
<td>7.1 Network board measures</td>
</tr>
<tr>
<td>7.2 NSSG measures</td>
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<td>7.3 Trust MDT measures</td>
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<thead>
<tr>
<th>8. Incidence/mortality/survival</th>
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<tbody>
<tr>
<td>8.1 – Incidence rates</td>
</tr>
<tr>
<td>Trachea, Bronchus and Lung (C33-34)</td>
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<tr>
<td>Mesothelioma (C45)</td>
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<tr>
<td>8.2 – Mortality rates</td>
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<tr>
<td>Trachea, Bronchus and Lung (C33-34)</td>
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<tr>
<td>Mesothelioma (C45)</td>
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<tr>
<td>8.3 – Population Survival rates</td>
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<tr>
<td>Trachea, Bronchus and Lung (C33-34)</td>
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<tr>
<td>1 year survival by cancer network</td>
</tr>
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<td>1 year survival by age group</td>
</tr>
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<td>8.4 – Provider level survival rates</td>
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<tr>
<td>Median Survival of patients</td>
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<tr>
<td>3 month survival</td>
</tr>
<tr>
<td>1 year survival</td>
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<tr>
<td>8.5 – Number of cases</td>
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<tr>
<td>8.6 Number of deaths</td>
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<th>9. Cancer Research</th>
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<tbody>
<tr>
<td>9.1 NCRN clinical trials data</td>
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Collated by Stephen Scott stephenscott@nhs.net

In strictest confidence – For NHS internal use only
Information included in metrics

- Cancer Waiting Times date – included up to Q3 2013/14 (December 2013)
- Staging completeness in MDT feed to National Cancer Registration service
- Published details from LUCADA including survival figures
- Details of submissions to Systemic Anti-Cancer Therapy Dataset (SACT)
- Results from National Cancer Patient Experience Surgery (NCPES) – Key questions
Information included in metrics - continued

- Routes to diagnosis
- Peer review details
- Incidence, mortality and survival rates (population)
- Numbers of cases and deaths (population)
- Details of NCRN trials recruitment – 2012/13
- Peaks at week before day 62 (same patterns seen in all tumour types apart from breast and skin)
- 13 patients waited longer than 18 weeks
Top 10 regimens, submitted to Systemic Anti Cancer Therapy (SACT) dataset - all LCA trusts
Lung Cancer (all excluding Mesothelioma) - October 2012 – September 2013

- CARBOPLATIN + ETOPOSIDE: 8,295 cycles
- GEMCARBO: 5,872 cycles
- CARBOPLATIN + PEMETREXED: 4,852 cycles
- ERLOTINIB: 3,820 cycles
- CISPLATIN + PEMETREXED: 3,439 cycles
- CARBOPLATIN + VINORELBINE: 3,035 cycles
- CISPLATIN + VINORELBINE: 2,513 cycles
- GEFTINIB: 2,020 cycles
- DOCETAXEL: 1,527 cycles
- PEMETREXED: 1,519 cycles
Numbers of cases/deaths of lung cancer

Number of cases - 2010

<table>
<thead>
<tr>
<th>Pathway group</th>
<th>Total LCA cases 2010</th>
<th>% of total cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>3827</td>
<td>19%</td>
</tr>
<tr>
<td>Breast</td>
<td>3339</td>
<td>17%</td>
</tr>
<tr>
<td>Lower GI</td>
<td>2453</td>
<td>12%</td>
</tr>
<tr>
<td>Lung</td>
<td>2424</td>
<td>12%</td>
</tr>
<tr>
<td>Haematology</td>
<td>1845</td>
<td>9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>1156</td>
<td>6%</td>
</tr>
<tr>
<td>Upper GI (HPB)</td>
<td>931</td>
<td>5%</td>
</tr>
<tr>
<td>Head and Neck</td>
<td>877</td>
<td>4%</td>
</tr>
<tr>
<td>Upper GI (OG)</td>
<td>830</td>
<td>4%</td>
</tr>
<tr>
<td>Skin (exc C44)</td>
<td>675</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>610</td>
<td>3%</td>
</tr>
<tr>
<td>Brain/CNS</td>
<td>381</td>
<td>2%</td>
</tr>
<tr>
<td>Sarcoma</td>
<td>228</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total invasive cancers (exc C44)</strong></td>
<td><strong>19576</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Number of deaths 2011

<table>
<thead>
<tr>
<th>Pathway group</th>
<th>Total LCA deaths 2011</th>
<th>% of total cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung</td>
<td>2101</td>
<td>23%</td>
</tr>
<tr>
<td>Urology</td>
<td>1144</td>
<td>13%</td>
</tr>
<tr>
<td>Lower GI</td>
<td>1028</td>
<td>11%</td>
</tr>
<tr>
<td>Upper GI (HPB)</td>
<td>834</td>
<td>9%</td>
</tr>
<tr>
<td>Breast</td>
<td>757</td>
<td>8%</td>
</tr>
<tr>
<td>Haematology</td>
<td>740</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>740</td>
<td>8%</td>
</tr>
<tr>
<td>Upper GI (OG)</td>
<td>629</td>
<td>7%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>469</td>
<td>5%</td>
</tr>
<tr>
<td>Brain/CNS</td>
<td>269</td>
<td>3%</td>
</tr>
<tr>
<td>Head and Neck</td>
<td>253</td>
<td>3%</td>
</tr>
<tr>
<td>Skin</td>
<td>162</td>
<td>2%</td>
</tr>
<tr>
<td>Sarcoma</td>
<td>84</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total invasive Cancers (C00-97)</strong></td>
<td><strong>9210</strong></td>
<td><strong>100%</strong></td>
</tr>
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</table>
Discussions with National Cancer Registration team/London Knowledge and Intelligence team

- Lung Cancer used as a pilot along with AOS to request COSD data from the London KIT – Requested in November 2013
  - CT scan before or on day of 1st OPA
  - Number of surgical procedures undertaken by provider
  - % of NSCLC having surgical resection
  - % of patient allocated a CNS
  - % of SCLC with a chemotherapy treatment within 2 weeks of a pathological diagnosis
  - % of patients on a clinical trial
Next steps

- Continue to update metrics with published data
- Further comparisons of 62 day waits by providers – e.g. comparing chemotherapy and radiotherapy waits
- Further breakdowns of SACT data (including trust level data)
- Include information from COSD, provided by London KIT team
Questions?
Feedback from the Lung Pathology Meeting

Dr Liz Sawicka
Setting Higher Standards in Lung Radiology
- Results of CT audit

Dr Paras Dalal, Royal Brompton and Harefield Foundation Trust
Dr Anand Devaraj, St Georges Healthcare NHS Trust
Audit: Access to Lung Diagnostics
Section 3: CT
Access to Lung Diagnostics Audit - CT

• Should the majority of patients with suspected lung cancer be seen in the chest clinic for the first time with the results of the CT scan, within two weeks?
Access to Lung Diagnostics Audit - CT

• 10 patients referred as TWR per trust
• Dates captured:
  – Date of Two Week Referral (TWR)
  – Date of chest physician being made aware of TWR
  – Date of CT request if CT deemed necessary
  – Date of clinic appointment
  – Date of CT acquisition
  – Date of CT report
• Some dates missing so not all charts reflect all trusts (i.e. if a trust is missing from a chart it means the date ranges were not completed)
• CT request, acquisition and report can all pre-date Two Week Referral date (hence some negative values)
Each bar represents the days between the Two Week Referral and the Clinic Appointment for an individual patient (including those with waits of zero days) for all trusts in the audit who responded, sorted in size order, to show the distribution (and median) across all patients in the dataset.
Each bar represents the days between the Two Week Referral and the CT Request (which may have been prior to the Two Week Referral – hence the negative values) for an individual patient (including those with waits of zero days) for all trusts in the audit who responded, sorted in size order, to show the distribution (and median) across all patients in the dataset.
Days from Clinic Appointment to CT Acquisition

Median = 3

RBH10, 82
RBH2, 76
Each bar represents the days between the CT Acquisition to the CT Report for an individual patient (including those with waits of zero days) for all trusts in the audit who responded, sorted in size order, to show the distribution (and median) across all patients in the dataset
Access to Lung Diagnostics Audit – CT discussion points

• Is there a delay for some chest physicians to be made aware of the TWR?

• For TWR clinic appt to be achieved with CT results available at time of appointment: CT needs to be performed on average within approx. 10 days (achieved by 5-8 trusts)
  – Carved out slots (?lung cancer only)
  – Direct referrals from radiology
  – Sufficient capacity
  – Other solutions?

• What is the expected CT report turnaround time?
Coffee Break

Please take the opportunity to view the BTOG posters
Development of ‘Living Well’ –
A health and wellbeing programme for thoracic cancer patients

Paula Tindale-Paul, Nicola Acworth, Emma North, Nicola Peat, Rhys White, Melissa Williams & Geraldine Handford

Guy’s & St. Thomas’ NHS Foundation Trust
Background

• Existing supportive care clinic (2009).
• Support group (Lung, mesothelioma).
• Holistic Needs Assessment (HNA) – Identified need for change to best address symptom management and supportive care needs.
• Increasing national focus on ‘cancer survivorship’.
• Growing evidence that support programmes have a positive effect upon quality of life and psychological functioning.
Method

- Multi-professional team (occupational therapists, physiotherapists, dietitian, lung CNS & respiratory nurse).
- 6 week programme.
- Exclusion criteria: anaemia, Hb <80g/L, untreated brain mets/cognitive issues restricting ability to participate in group sessions.
- Each session was paced to optimise patient care allowing interventions to be tailored to individual’s situations, stage of disease and their wishes.
Referral
Received from Medical, CNSs, AHPs, Self referral

Phone call and screening assessment

‘Living Well’ Sessions:
- Catching your breath
- Keeping Active
- Time to relax
- Eating well
- Managing your energy
- Keeping on top of things

Outcome measurements
- 3 question evaluation post each session
- Patient satisfaction questionnaire (CSQ-8) post attending 6 sessions

Follow up phone call and onward referral to ongoing supportive / rehabilitation services if required.
Findings

• **ALL** patients reported an improvement in their ability to self manage their symptoms.

• **ALL** patients reported that anxiety was reduced.

• The mean score for the overall rating question on CSQ-8 evaluation score was **9.7/10**.

• 9 patients attended the programme, however only 3 completed all 6 sessions.

• Total session attendance was 28.
Summary and Proposals

• Supports the trusts and national cancer strategies around survivorship and rehabilitation and has proved to be a valuable intervention output following HNA across the cancer pathway.
• Small numbers BUT very well received.
• Adapt programme – 3 weeks.
• Re establish lung cancer support group. In addition to physical activity group enabling patients to access support and rehabilitation regardless of level of function or stage of disease.
• Adapt and translate model > other tumour groups within the trust.
Early Diagnosis
Community Pharmacy Referrals Project: Increasing awareness and early diagnosis of respiratory disease via a direct pathway to secondary care

Dr Ravi Punwani
Clinical Research Fellow
The Royal Marsden Hospital
The Lost Tribe

- Not registered with GP or does not attend
- Frequent A & E attendance
- Undiagnosed/untreated co-morbidities
- We need to reach these patients
Aims

• Target the lost tribe – at risk of lung cancer – not visiting their GP
• Improve awareness of symptoms amongst at risk populations and other healthcare professionals (pharmacists)
• Key to improving lung cancer survival in the UK?
  – *Earlier diagnosis* – therefore *improve access to diagnosis and treatment for respiratory disease*
• Increase smoking cessation referral
Background

• NAEDI funded pilot targeted high risk groups (cancer SMR>100, high deprivation, high smoking rates, low life expectancy) in SW London

• Established direct referral pathway from community pharmacists to secondary care

• Complement existing referral pathways and systems

• New COPD diagnosis in 15% of patients seen
Method

• 42 pharmacies within target area (Croydon, Wandsworth, Merton, Sutton)
• 6 month study
• Promotional material – GPs, pharmacists, community centres
• Pharmacists and counter staff attended training sessions to learn how to identify, counsel and refer appropriate patients (cough mixture, NRT):
  – >50 years old
  – Current or ex-smokers (pack year history)
  – Symptoms: Cough, SOB, chest pain, weight loss (>3/52)
• Patients seen at Croydon and St George’s Hospital
• Clinical assessment, chest x-ray and spirometry
• Anonymous questionnaire from patient

• Funded by SWLCN
Results

• 55 appropriate referrals received
• 47 seen in clinic over 6 month study period
• New diagnosis of COPD in 14 patients (30%)
• All smokers offered referral to cessation services
• 94% patient satisfaction
• High levels of pharmacist satisfaction
• 2 SPN required follow up

New COPD diagnosis (14 patients) 30%

No new diagnoses made (16 patients) 34%

Other Diagnoses (17 patients) 36%

Other Diagnoses

Asthma 13%
ACE-I cough 7%
Pneumonia 6%
Bronchitis 4%
GORD 2%
CCF 2%
Anxiety 2%

(16 patients) 34%
Conclusion

Community pharmacists are an acceptable and underutilised resource that can be used to identify and refer patients at risk of smoking related respiratory disease.
Dispensing Health

Supports expanded role of pharmacists in healthcare

*The Times, January 2014*

Accessible
Longer hours
Easier to talk to than GP
No appt needed
The London Cancer Alliance West and South

Next Phase

Community Pharmacists
- Spirometry

Senior Nurse Practitioner
- Receive referrals
- Telephone screening call
- Request CXR
- Liverpool Lung Project score

General Practitioner

Secondary Care Chest Clinic
- MDT Leads

Follow up phone call on symptoms and smoking cessation success

Smoking Cessation

Receive referrals

Telephone screening call

Request CXR

Liverpool Lung Project score

Follow up phone call on symptoms and smoking cessation success
Next Phase

• Expand to 300 referring pharmacists
• Aim to receive 1000 referrals over 1 year
• Approximately 100 per LCA MDT (10-13)
• Half may need clinic appointment i.e. 1 per week
• Rest referred to GP/followed up by nurse
• Applied for Roy Castle Lung Foundation grant
Thank you

• Questions?

ravi.punwani@rmh.nhs.uk

• Acknowledgements: NAEDI, Dr O’Brien, Dr Draper, Dr Loke, Dr Keddie, Dr Nimako & the outpatient staff at St George’s and Croydon University Hospitals and participating pharmacists
Raising the Awareness of the Signs and Symptoms of Lung Cancer to the General Public

A Collaboration Between The British Lung Foundation and The Lung Cancer CNS Team at GSTT.
Project Overview

• The purpose of the ‘love your lungs’ campaign was to raise awareness of lung disease and to provide a screening service for members of the public.

• The campaign particularly aimed to raise awareness of lung cancer as Haringey had been highlighted as a hotspot area.

• The campaign also highlighted the importance of good lung health.
Project Design

• A workshop designed by the lung cancer CNS team at GSTT to train health champions around signs and symptoms of lung cancer.
• The health champions were all volunteers and members of the general public.
• The health champions then attended the public events to support the healthcare professionals.
The Event

• A GSTT lung cancer CNS represented the BLF at an awareness event in a shopping centre in Wood Green.

• The CNS completed screening on 35 individuals for possible symptoms of lung cancer.

• From the assessments completed approximately 8 patients were referred to their local GP for further investigations and follow up.
Key Outcomes

• Across the two events 163 individuals were tested.
• 49% were referred on to their GP for further testing.
• 84% of those referred did visit their GP as advised.
• 87% of individuals reported that the campaign had increased their awareness of lung cancer.
Quotes

“Just the fact that to be able to test the health of your lungs and be given advice free of charge is excellent. Many thanks.”

“Visually the stand was appealing and inviting, people felt that they wanted to come and chat to us. There were a number of BLF staff and health champions available and the written information was great.”
Impact of lung cancer acute admissions in London

Dr Tom Newsom-Davies
Chelsea and Westminster Hospital NHS Foundation Trust
A Retrospective Cohort Analysis of the Differences in Care and Treatment of Patients with Lung Cancer Based on Age

Dr Gamunu Ratnayake
Respiratory SpR, Guy’s and St Thomas’ Hospital
Introduction

- A recent Macmillan survey of 155 GPs, oncologists and specialist nurses suggested that 45% of patients were refused treatment based on age [1].

- The Edinburgh lung cancer group showed that lung cancer survival is not associated with age. Therefore there should be no age discrimination for lung cancer treatments.
Methods

• Retrospective cohort study

• 232 patients diagnosed with any primary lung cancer between January 2011 and November 2012.

• Review of lung cancer MDT records and clinic letters.

• 3 age brackets: <70, 70-80 and >80 years old.
Results I

Figure 1: Methods of diagnosis for each age group. Clinical investigation: diagnosis of lung cancer based on history, examination and CT result, without tissue confirmation.
Results II

Figure 2: The cumulative survival for the different age groups.
Results III

Figure 3: Graph showing percentage of patients receiving treatment planned within the multi-disciplinary team meeting and reasons for diversion from planned primary treatment.
Conclusions

• Patients older that 80 have fewer GP referrals as a proportion compared to younger patients.

• Significantly fewer patients over 80 have a histological diagnosis.

• The majority (60%) of patients refusing active treatment were over 80 years old.

• No significant difference in survival between groups.
Questions
Summary and Close

Chair
Dr Liz Sawicka
Thank you for coming today

Presentations will be available on the website shortly.

www.londoncanceralliance.nhs.uk