National Institute for Health and Care Excellence

Quality Standards Advisory Committee 3 meeting
Date: Wednesday 15 May 2019
Location: NICE office, Level 1a City Tower, Piccadilly Plaza, Manchester, M1 4BT

Lung cancer (update) – prioritisation of quality improvement areas

Minutes: Draft

Attendees

Quality Standards Advisory Committee 3 members:
Jane Dalton, David Pugh, Phil Taverner, Carolyn Chew-Graham, Madhavan Krishnaswamy, Jim Stephenson (vice chair), Ivan Benett, Amanda De La Motte, Keith Lowe, Malcolm Fisk, Ann Nevinson

Specialist committee members:
Tom Haswell, Douglas West, Shahzeena Aslam, Andrea McIver, Sue Maughn, Lynn Campbell, Neal Navani

NICE staff
Nick Baillie (NB), Melanie Carr (MC), Julie Kennedy (JK), Jamie Jason (notes)

Apologies
Hugh McIntyre, Darryl Thompson, Nadim Fazlani, Deryn Bishop, Julia Thompson
Specialist committee member: Sujal Desai

1. Welcome, introductions objectives of the meeting
The Chair welcomed the attendees and the quality standards advisory committee (QSAC) members introduced themselves. The Chair informed the committee of the apologies and outlined the objectives of the meeting, which was to prioritise areas for quality improvement for the Lung cancer (update) quality standard.

The Chair welcomed the public observers and reminded them of the code of conduct that they were required to follow.

2. Confirmation of matter under discussion and declarations of interest
The Chair confirmed that, for the purpose of managing conflicts of interest, the matter under discussion was the Lung cancer (update) specifically:

- Public awareness
- Diagnosis and staging
- Improving health outcomes
- Treatment
- Care and support
- Palliative care

The Chair asked standing QSAC members to declare verbally any interests that have arisen since the last meeting and all interests specifically related to the matters under discussion. The Chair asked the specialist committee members to verbally declare all interests.

3. Minutes from the last meeting
The committee reviewed the minutes of the last QSAC 3 meeting held on 24 April 2019 and confirmed them as an accurate record.

4. Prioritisation of quality improvement areas – committee decisions

MC provided a summary of responses received during the Lung cancer (update) topic engagement,

referred the committee to the full set of stakeholder comments provided in the papers and the committee then discussed each of the areas in turn. The committee discussed the comments received from stakeholders and specialist committee members at topic engagement **(in bold text below)**.

The committee noted that Public Health England, the Royal College of Physicians and the Royal College of Nursing did not respond during engagement and this should be followed up at consultation.

Action: NICE team to engage with Public Health England, Royal College of Physicians and Royal College of Nursing during consultation.

Public awareness – Prioritised

The committee discussed the importance of public awareness campaigns to prevent late diagnosis. Although the national 'Be clear on cancer' campaigns have shown a national effect, there was not a great effect at a local level. The committee also discussed that NHS England are piloting lung cancer screening in specific areas.

Within this context, the committee agreed that local awareness campaigns are still very important in order to support a community-based approach which engages harder to reach groups and encourages behaviour change. Local campaigns should include people who smoke but also ensure that people who don't smoke are also aware of the risk. The committee agreed that public awareness should be progressed as a priority area.

Action: NICE team to progress a statement on public awareness.

Diagnosis and staging - Prioritised

a) **Diagnostic pathway**
b) **Investigations**
c) **Communication**

The committee discussed the diagnostic pathway. The national optimal lung cancer pathway is already being implemented alongside the new 28-day diagnosis standard and therefore the committee agreed not to prioritise this.

The requirement for a pathological diagnosis was also discussed. It was agreed that this is important but is already included in the national audit. It is not clear what proportion of people with lung cancer should have a pathological diagnosis. The committee therefore agreed not to prioritise this.

The committee discussed investigations. It was suggested that it is a priority to ensure that people who are being considered for treatment with curative intent have the necessary investigations prior to treatment starting, including PET-CT, brain imaging and transfer factor. People with stage 2 lung cancer or higher should receive brain imaging. The wording 'diagnostic bundle' is already used in the national optimal lung cancer pathway but the definition is different to the NICE guideline. It was agreed that diagnostic investigations prior to treatment with curative intent should be progressed as a priority area.

The committee discussed the need for timely communication with people having diagnostic investigations. Although written information is important, the committee agreed that the priority is for someone to have a named clinical nurse specialist who can provide information and support during diagnosis. It was therefore agreed that although this issue is important it should be included within the area on care and support.

Action: NICE team to progress a statement on diagnostic investigations prior to treatment with curative intent.

Improving health outcomes - Prioritise

a) **Smoking cessation**
b) **Prehabilitation**

The committee discussed smoking cessation. It is important for people diagnosed with lung cancer to stop smoking because it is associated with complications following treatment. Stopping smoking can increase life expectancy and improve quality of life. People need specialist support to stop smoking but this can be an inexpensive and very effective intervention. It was agreed that currently there is variation in access to and quality of smoking cessation services. Sometimes people are just given a leaflet and take up of support is low. The committee agreed that smoking cessation should be progressed as a priority area.

The committee discussed prehabilitation including pulmonary rehabilitation. It includes exercise, diet and getting fitter before treatment which can improve outcomes. There are no recommendations in the lung cancer guideline for prehabilitation and there is no evidence base. It could also lead to a delay in treatment being provided which would not support implementation of the national optimal lung cancer pathway. Although prehabilitation was recognised as helpful the committee agreed not to prioritise it as an area for the quality standard.

Action: NICE team to progress a statement on smoking cessation.

Treatment- Prioritised

a) **Treatment with curative intent for non-small cell lung cancer (NSCLC)**
b) **Systemic anti-cancer therapy (SACT)**
c) **Chemotherapy for small cell lung cancer (SCLC)**

The committee discussed the variation in people over 70 having treatment. Age shouldn't be a factor in the decision to treat but factors such as fitness and comorbidities do affect treatment options.

The committee also discussed why treatment might not be taken up when offered. It could be cultural beliefs, poverty or not wanting to travel. If a more effective treatment is offered but requires the person to travel, they may choose to have a less effective treatment if it can be provided locally. Support from a healthcare professional can help to improve take-up of treatment.

There is a lot of interest in minimally invasive surgery, but a major trial is still underway and there are no specific recommendations on this in the guideline, so it was agreed not to prioritise this area.

Some of the key metrics in relation to treatment are already covered in the national lung cancer audit, for example: 14-day target for chemotherapy for SCLC, resection rates, access to SACT, 1-year survival.

The committee agreed that the priority is to ensure that people with stage 1 to 3a NSCLC and good performance status receive treatment with curative intent.

Action: NICE team to progress a statement on treatment with curative intent for NSCLC.

Care and support - Prioritised

a) **Clinical Nurse Specialist (CNS)**
b) **Holistic needs assessment**
c) **Follow-up after treatment**

The committee discussed care and support. Access to a clinical nurse specialist and a holistic approach are key priorities. It was agreed that it is feasible for everyone with lung cancer to have access to a lung CNS and evidence shows that this will improve outcomes and survival.

The way that services are organised means that people are unlikely to have the same CNS throughout as nurses are specialised e.g. diagnosis, oncology and palliative care. There has been less emphasis on the role of the CNS in supporting diagnosis, but this is recognised in the national optimal pathway. It is important to emphasise a team approach ensuring an appropriate skill mix.

The committee agreed that access to a lung CNS throughout the care pathway should be progressed as a priority area.

The evidence-base on follow-up after treatment is still developing and therefore it was agreed that this area is not suitable for inclusion in the quality standard.

Action: NICE team to progress a statement on access to a lung CNS throughout the care pathway.

Palliative care – not prioritised

a) **Enhanced supportive care**
b) **Management of brain metastases**

The committee discussed when it is appropriate to refer someone for palliative care and agreed that if the person has a lung CNS this should ensure they are referred at the most appropriate time, based on their individual circumstances and preferences.

The committee discussed the end of life care for adults quality standard which is due to be updated following publication of the NICE guideline. It was agreed that access to palliative care should be covered in that QS. Also, the existing statement in the lung cancer quality standard will also still be available for local areas to use.

The management of brain metastases was not prioritised as an area for the quality standard as it is based on a clear 'do not do' whole-brain radiotherapy recommendation in the guideline.

The committee agreed not to progress this as a priority area but indicated that there should be a signpost to the end of life care quality standard.

5. **Additional quality improvement areas suggested by stakeholders at topic engagement**

The following areas were not progressed for inclusion as separate statements in the draft quality standard.

- Lung cancer screening – This is beyond the scope of the quality standard.
- Resources for MDT's – The committee discussed the importance of ensuring that key skills are represented within MDT's e.g. surgeons, as this can be associated with an improved resection rate. There is a service specification from NHS England regarding the quoracy of MDTs. This issue is common across all cancers. The committee agreed not to prioritise MDT as a statement but to include it as a structure measure within the statement on treatment.
- Funding to develop diagnostic tests and treatments – This is beyond the scope of the quality standard.

The committee also discussed the importance of ensuring that adequate samples are taken at biopsy to support molecular testing based on recommendation 1.3.11 in the lung cancer guideline. The committee agreed to prioritise this area as it is important to support access to genetic testing and ensure the most appropriate treatment is provided.

Action: NICE team to progress a statement on quality of tissue sampling to support molecular testing.

6. Resource impact and overarching outcomes

The committee considered the resource impact of the quality standard and at this stage agreed with the information provided that based on the guideline, none of the areas are likely to have a significant resource impact.

The committee discussed the draft overarching outcomes and suggested that length of hospital stay may not be appropriate. The committee agreed to provide further input on the overarching outcome once the quality standard is drafted.

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7. Equality and diversity

The committee agreed the following groups should be included in the equality and diversity considerations:

- Age

- Gender reassignment
- Pregnancy and maternity
- Religion or belief
- Marriage and civil partnership
- Disability
- Sex
- Race
- Sexual orientation

The following was also noted:

- Transport
- Gender
- Men's response to lung cancer
- Geographical
- Prisoners
- Mental ill
- Deprivation
- Age
- Older women

Specific issues highlighted at this stage were:

- Geographical variation with transport to treatment a particular problem for rural populations
- High prevalence linked to socioeconomic deprivation
- Access to treatment for older people
- People in prison and those who are mentally ill.

8. Any other business

The Chair informed the committee that there will be a meeting on 17 July.

9. Close of the meeting