Lung Cancer Quality Performance Indicator (QPI) Engagement Document – Revised QPIs

Comments Form

We welcome your views on the **Draft Revised Lung Cancer QPI Engagement Document**, in particular comments on:

- The appropriateness of the QPIs that have been developed.
- The target levels that have been set.
- Key points or areas that are not covered within the engagement document or QPIs.
- Feasibility of measuring the QPIs identified in a meaningful and comparative way (i.e. 'like for like' comparison)

All comments are welcome, whether they are on all or part of the QPIs and are positive or negative. Comments can be submitted anonymously however we would be grateful if you could provide contact details, should any further clarification on comments be required.

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Feedback and Comments on Revised Cancer QPIs:

QPI		Comments (please provide supporting evidence where appropriate)
1	Multi-Disciplinary (MDT) Meeting	This seems appropriate - the College would appreciate clarity on the denominator being 'all patients with lung cancer': does this mean cancer registry data?
2	Pathological Diagnosis	This seems appropriate – however, again the same comment regarding denominator.
4	PET CT in patients being treated with curative intent	This seems appropriate.
5	Investigation of mediastinal malignancy	This seems appropriate.

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QPI		Comments (please provide supporting evidence where appropriate)
6	Surgical resection in non small cell lung cancer	This is reasonable.
7	Lymph node assessment	This is an important target but is an area where there is a great variation in surgical practice even within Scotland. It has been a problem for the reporting Pathologists for many years: it would be helpful for surgeons and their local pathologists to agree the terminology and location of the mediastinal nodes that could be sampled at time of surgery.
8	Radiotherapy in inoperable lung cancer	This generally seems appropriate. However, the exclusion of "patients who die prior to treatment" could be clarified? Does this mean patients who are referred for radical radiotherapy but die before it can be given: there are no time periods for this statement and a poor service with a long waiting list may have better figures because of exclusions. This could perhaps be a separate QPI (waiting time for radical XRT in lung cancer).
9	Chemoradiotherapy in locally advanced non small cell lung cancer	This seems generally appropriate with the same comment about treatment waiting time.
10	Chemoradiotherapy in limited stage small cell lung cancer	Same comments as 9.
11	Systemic anti cancer therapy in non small cell lung cancer	This is appropriate and up to date.
12	Chemotherapy in small cell lung cancer	This seems appropriate.
13	Mortality following treatment for lung cancer	This is a complex QPI which attempts have been made to simplify. In curative treatments 30 day mortality is related to the complications of therapy/surgery and 90 day mortality is related to treatment failure (disease recurrence). By having one target figure it is not possible to distinguish these two effects.

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QPI		Comments (please provide supporting evidence where appropriate)
14	New QPI – SABR – Stereotactic ablative body radiotherapy	The College would appreciate clarification regarding the availability of this new form of treatment. Same comment as above regarding reasonable waiting time for treatment.
15	New QPI – Pre-treatment Diagnosis	This is reasonable.

Any further comments:

QPI 16 – Clinical trial access. This is reasonable although the denominator should be "patients discussed at lung cancer MDTs". Patients not discussed at MDT (about 5% of lung cancer patients on the cancer registry) have **no** chance of being assessed for a clinical trial and should be excluded from the analysis.

Generally these QPIs are improving and are relevant to the management of lung cancer patients in 2016. They are easily measureable. Since the majority of lung cancer patients are treated with palliative intent it would seem important that future QPIs make an attempt to measure more subjective areas such as symptom control and Quality of Life.

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