IMPROVING LUNG CANCER OUTCOMES IN ENGLAND

The clinical communities approach

The Health Foundation
Inspiring Improvement

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Background and methods

In England, there is geographical variation in care for lung cancer patients that prevails even when corrected for case-mix (i.e. surgical resection rates can vary from 6% to 25% across regions, 2009, National Lung Cancer Audit (NLCA)[1]). Lung cancer patients are cared for by multidisciplinary teams, which were established to improve patient care, data collection and communication with patients[2]. The core team members are the respiratory clinical lead, the specialist lung cancer nurse and the team coordinator.

The Improving Lung Cancer Outcomes Project (ILCOP) was a two year long programme of quality improvement (QI) activities. The aim was to create a community of professionals in order to:

a) identify reasons for variation in care
b) support the implementation of changes, and
c) contribute to the knowledge base on how best to engage clinicians in QI activities.

Activities were evaluated using anonymous feedback, interviews and observations by external researchers.

Results

Lung cancer teams from the intervention Trusts (fig 2):

- participated in three workshops
- participated two peer-led service reviews with their paired trust
- distributed three sets of 30 patient questionnaires.

The peer-led service review phase took six months to complete, with more than 235 lung cancer team members (see figure 3) participating in the 30 service reviews (see figure 4 for feedback).

Teams were supported in designing and implementing their QI plans by the QI facilitator and peers through additional service visits by the QI facilitator, email, web conferencing and telephone. 71 QI plans were submitted by 97% of intervention teams. Teams worked to collect data to demonstrate patient level impact on their changes for improvement (see figure 5). The average return rate of patient experience questionnaires was estimated at 48% for surveys 1 and 2.

Conclusions

The clinical communities approach has achieved great engagement by bringing together a large number of healthcare professionals in a manner that is seen as supportive and yet opens up the possibility to legitimately challenge existing ways of working. Formal training may be required to support teams in implementing QI plans that can effectively impact on health outcomes rather than service processes.

How to engage with clinicians with no prior QI background:

1. avoid QI jargon
2. focus plans on clinically relevant, measurable and achievable outcomes
3. offer targeted support from the quality improvement facilitator
4. face to face, as opposed to web-based, opportunities to share learning.

How to create a community of improvers:

1. create new relationships amongst the participants and help them to keep those alive
2. provide multiple approaches for participants to interact
3. develop local expertise in measuring performance variation at frequent intervals.

Figure 1. **Recruitment process**

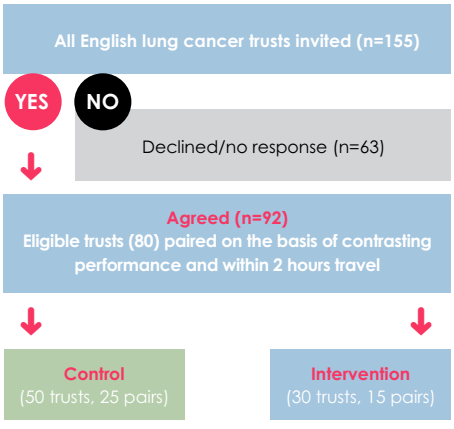


Figure 2. **Trusts in the ILCOP intervention arm**

Figure 3. **Breakdown of participants in peer-led service reviews**

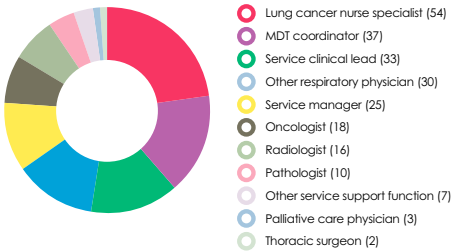


Figure 4. **Feedback: ability of the peer-led service reviews to identify areas for improvement**

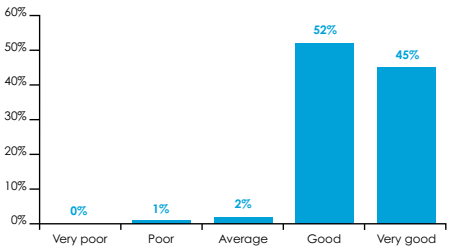
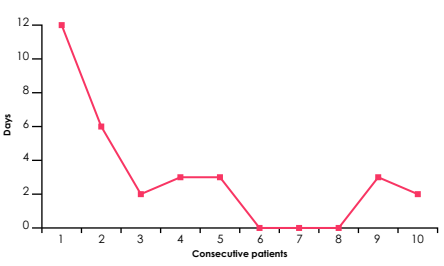


Table 1. **Quality improvement plans**

Area for improvement	Number of QI plans
NLCA Indicators	43
Patient experience	9
Meeting effectiveness	14
Generic data collection	7

Figure 5. **Example of data collection: waiting time from MDT meeting to therapy for small cell lung cancer**



"This project created an opportunity for people who've been sitting in their teams thinking 'This isn't right' but not quite knowing how they could improve it. ILCOP suddenly opened up ideas for them to be able to do that."

1. National Lung Cancer Audit report (2009) NHS Information Centre for Health and Social Care.
2. The Characteristics of an Effective Multidisciplinary Team (2010) NHS National Cancer Action Team.