

selected to pose more of a challenge to MDTs. Nevertheless, each of these cases had a pre-defined preferred treatment option.

**Results** The three cases rated straight-forward produced good agreement between MDTs, (Abstract P153 table 1) for radical vs palliative treatment. More complex cases resulted in less agreement between MDTs. One case (number 5) was excluded from analysis as it was clearly too ambiguous for MDTs to properly assess.

**Conclusions** We conclude this method to compare decision making by MDTs is a feasible tool. A roll-out is now planned to a further 50 MDTs to document more clearly the variation in decision making UK-wide. Even with this small sample of MDTs for just two Networks, complex cases clearly produce greater variation in the proportion of patients offered radical treatment.

**REFERENCE**

1. **The Information Centre National Lung Cancer Audit.** 2010. *Report for the Audit Period.* 2009. Ref IC03020211.

**P154 THE IMPROVING LUNG CANCER OUTCOMES PROJECT: A STUDY OF THE FEASIBILITY OF A NATIONAL RECIPROCAL PEER REVIEW AND FACILITATED QUALITY IMPROVEMENT PROGRAMME**

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**Background** Variation exists in lung cancer outcomes in the UK, which does not appear to be wholly explained by differences in case mix. The Improving Lung Cancer Outcomes Project aims to address this via a 2 year programme of national reciprocal peer review and facilitated quality improvement. We describe the feasibility and acceptability of delivering this programme over the first year.

**Methods** All NHS trusts in England were invited to take part. Those who agreed were paired on the basis of contrasting results in four headline indicators from the national lung cancer audit. 15 pairs were randomised to the intervention arm and the remaining pairs acted as controls. The intervention group were invited to participate in workshops, reciprocal site visits, patient experience surveys and facilitated quality improvement (QI) work. Evaluation of this activity was performed using anonymous feedback, interviews with participants and observations of programme activities by external researchers.

**Results** 92 of 156 (59%) trusts agreed to participate. The site visits for the 15 pairs in the intervention arm took 6 months to complete and were attended by a total of 210 MDT members. The visits were seen as supportive yet opened up the possibility of legitimate challenge to existing ways of working. All 30 trusts in the intervention group were represented in the first patient survey, which had an overall response rate of 49%. However returns for individual trusts were low which reduced perceived credibility in some cases. 71 QI plans were submitted by 29 of the 30 trusts. These focused on a range of areas including data collection, diagnostics, and access to clinical nurse specialists. Considerable revision of the QI plans was required to ensure alignment with the overall project aims.

**Conclusions** We have demonstrated that reciprocal peer review and facilitated quality improvement planning is both feasible and acceptable as part of a national lung cancer improvement project. Organising timely site visits, providing credible patient feedback and maintaining the focus of quality improvement plans is challenging and requires considerable resource. The overall effect of the programme on patient experience and outcomes is awaited with interest.

**P155 GP EDUCATION OF THE EARLY SYMPTOMS OF LUNG CANCER: DOES IT IMPROVE OUR EARLIER DIAGNOSIS OR STAGING OF LUNG CANCER?**

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**Introduction** Detection of lung cancer at an earlier stage generally leads to a better prognosis. In the UK, there is a 62-day target from GP referral to cancer treatment; therefore the opportunity to improve earlier detection of lung cancer, in terms of stage, is dependent on earlier “red flag” symptom recognition and referral. We hypothesised that GP education of the early symptoms of lung cancer should lessen time from symptom onset to time seen in the Respiratory outpatients (OPA).

**Methods** We introduced a health campaign across Essex consisting of GP education and public awareness. Phase 1 involved GP education and phase 2 patient and public education. We compared patients referred with a diagnosis of lung cancer, in one centre in 2010 and 2011 prior to and after GP education, to ascertain if time of onset of symptoms to first attendance at lung cancer OPA improved. Patients who had a diagnosis of lung cancer were entered into a prospective database. Data collected included symptom duration, referral times and staging. GP education comprised of seminars and group visits to the multidisciplinary members in GP practices, as well as provision of information packs. Data were collected by members of the lung cancer team.

**Results** Data demonstrated no significant difference in mean symptom duration, nor the number of patients being referred at an earlier stage (Abstract P155 table 1). However, there was a 50% increase in the number of GP referrals during the period following intervention.

**Conclusions** These results demonstrate that GP education has not significantly increased early detection of lung cancer, although it has dramatically increased the number of 2-week referrals, this is noteworthy, since awareness of lung cancer symptoms may have improved in the GP population following education. It may be that targeting the public/patients themselves, will reduce the time of symptom onset to presentation to the medical profession. We will address this in the next phase of our study when we aim the education at the general public. This will help determine the impact

Abstract P155 Table 1 Comparison of data from pre and post GP education

	PRE GP education January–July 2010	POST GP education January–July 2011
Number of 2 week referrals from GPs	140	210
Lung cancer patients referred by GP	77 (55%)	72 (34%)
Mean age and SD	69.8 years±10.66	73.1 years±9.74
Mean onset of symptoms: (no of patients)		
≤3 weeks: mean (n)	1 week (9)	2 weeks (3)
1–6 months: mean (n)	3.2 months (51)	3.2 months (53)
≥6 months: mean (n)	13.8 months (4)	11.3 months (3)
Unknown/incidental (n)	(13)	(13)
Stage of NSCLC		
IA	3 (4%)	6 (8%)
IB	3 (4%)	2 (3%)
IIA	4 (5%)	6 (8%)
IIB	3 (4%)	2 (3%)
IIIA	11 (14%)	10 (14%)
IIIB	6 (8%)	3 (4%)
IV	31 (40%)	29 (40%)
Mesothelioma	9 (12%)	4 (6%)
Small cell	7 (9%)	8 (11%)