

adjustment, start to explain the wide variations noted. Although Wales and Scotland also submit data to the audit, this abstract presents results for England only.

Results In Year 5, participation has again increased and the number of cases submitted has risen from 10 920 cases in 2005, to 16 922 in 2006, to 20 639 in 2007 to 25 757 in 2008, and to 30 155 in 2009. Completeness of data on individual cases has also improved—recording of PS has risen to 88%, stage to 80% and treatment to 89% of cases. Results suggest that the quality of care is improving, with annual increases in the proportion of patients being discussed in an MDT, proportion of patients receiving anti-cancer treatment, and in the surgical resection rate (see Abstract P210 Table 1). Data also show that the degree of variation across organisation is reducing year-on-year.

Abstract P210 Table 1 Process and outcomes

	2005	2006	2007	2008	2009
Confirmed histological diagnosis	68%	66%	65%	67%	70%
Discussed at MDT?	79%	84%	87%	89%	93%
Any anti-cancer treatment?	45%	50%	52%	54%	59%
Overall surgical resection rate	9%	9%	10%	11%	14%
NSCLC resection rate	14%	14%	15%	16%	19%
SCLC chemotherapy rate	58%	62%	65%	63%	66%

Conclusions These results once again highlight the considerable achievement of the National Lung Cancer Audit in collecting data and are a testament to the hard work of lung cancer teams across the country in achieving such high quality data on such a large scale. The results suggest that care for lung cancer patients is slowly improving, although some of the apparent improvement is likely to reflect the rise in data quality. However, wide variations in outcomes still persist between organisations, which need to be the focus of on-going service improvement work.

P211 ASSESSMENT OF OPERABILITY IN EARLY STAGE LUNG CANCER: RESULTS FROM THE NATIONAL LUNG CANCER AUDIT

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Background NICE guidelines recommend that patients who are staged as candidates for curative treatment on CT should undergo further evaluation with PET scan, mediastinal sampling (where appropriate) and lung function tests to confirm stage and to assess fitness for surgery. Under-use and/or variability in the interpretation of these investigations as well as the frequency of comorbidities may contribute to the relatively low surgical resection rates seen within England. These data are collected by the national lung cancer audit but have not previously been reported at a national level.

Methods Data are presented for patients submitted to the national lung cancer audit with histologically confirmed non-small lung cancer (NSCLC) first seen in England in 2008. It is anticipated that data for 2009 will be available for presentation at the meeting.

Results 13 488 patients (53%) had histologically confirmed NSCLC of which staging data were available for 11 661 patients. 2071 (18%) had stage I or II disease. Investigations and treatment for these patients are shown in the Abstract P211 Table 1 42% of patients with stage I disease who did not undergo surgery had good performance status (WHO 0-1) and adequate FEV1 for lobectomy (>1.5L). 23% of patients with stage II disease who did not undergo

surgery had good performance status and adequate FEV1 for pneumonectomy (>2.0L).

Abstract P211 Table 1

PET scan field completed	1711 (83%)
PET scan performed	1228 (72%)
Staging procedure performed	509 (26%)
Lung function recorded	1184 (57%)
FEV ₁ (L)	1.7 (1.30–2.23)*
FEV ₁ (% predicted)	74 (58–90)*
Surgery performed	1140 (55%)
Radiotherapy given	340 (16%)

*Median (IQR).

Conclusion PET scanning is generally being performed as recommended in national guidelines. The low level of recording of lung function may represent poor data completeness for this field or, more worryingly, under use of this test. The available spirometric data suggest that lung function is relatively well preserved in this group of patients. In particular, approximately one third of those patients who did not undergo surgery appeared to have adequate respiratory reserve and performance status to tolerate resection. The reasons why these patients did not undergo surgery require further evaluation at a local level.

P212 SCREENING FOR LUNG CANCER: A QUALITATIVE STUDY OF THE ACCEPTABILITY OF SCREENING AND PARTICIPATION IN THE LUNG-SEARCH TRIAL

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Introduction Lung cancer has the highest mortality of all cancers in the UK and, as such, constitutes a major public health problem. Lung-SEARCH is a UK multi-centre randomised control trial to determine whether screening (annual sputum cytology and if positive, followed by annual CT scanning and bronchoscopy) of smokers with mild COPD improves the detection of lung cancer at early stages when curative treatment is feasible. Acceptability is an ethical requirement of any screening programme. In addition, maximising participation of at-risk groups is key to any successful screening programme. We conducted a qualitative study to answer two questions:

1. Are the screening methods of the Lung Search trial acceptable to patients
2. Why do some people take part and others decline?

Methodology A qualitative study using semi-structured face-to-face and telephone interviews involving three groups of respondents a) those giving an annual sputum sample; b) those undergoing annual bronchoscopy and CT scanning, and c) those who declined participation in the trial. We used the Framework technique to carry out a thematic analysis. Respondent validation was used to strengthen the research findings.

Results 50 interviews were completed (group a: 16, group b: 11; group c: 23). Respondents felt sputum analysis and CT scanning was acceptable. Some recalled a negative experience of bronchoscopy but would not object to future bronchoscopies. The main reasons for declining the trial include travelling for CT scanning and bronchoscopy, negative experiences/perceptions of screening tests, and low perceived susceptibility of lung cancer. There were four main typological behaviours recognised within the declining group: 'too