GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)

Welsh Health Specialised Services Committee (WHSSC)

Specialised Services
Service Specification: CP144

Adult Thoracic Surgery

September 2020

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PARCH - RESPECT

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Description	NHS Wales will routinely commission this specialised service in accordance with the criteria described in this document
Document No	CP144a
Review Date	2024 Review date extended to May 2025

Contents

Statement

Welsh Health Specialised Services Committee (WHSSC) will commission the service of thoracic surgery in accordance with the criteria outlined in this specification.

In creating this document WHSSC has reviewed the requirements and standards of care that are expected to deliver this service.

Disclaimer

WHSSC assumes that healthcare professionals will use their clinical judgment, knowledge and expertise when deciding whether it is appropriate to apply this document.

This document may not be clinically appropriate for use in all situations and does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

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1. Introduction

This document has been developed as the Service Specification for the planning and delivery of thoracic surgery for people resident in Wales. This service will only be commissioned by the Welsh Specialised Services Committee (WHSSC) and applies to residents of all seven Health Boards in Wales.

1.1 Background

Thoracic surgery involves operations for conditions affecting the chest, including the lungs, mediastinum, pleura, diaphragm, the sympathetic nervous system, in some cases the pericardium and chest wall. It excludes conditions affecting the heart and great blood vessels (which are the remit of cardiac surgery) and the oesophagus (which are the remit of the upper GI surgeons).

The largest single disease requiring management by thoracic surgery is primary lung cancer. The remaining conditions include other types of thoracic malignancies, pneumothorax (collapsed lung), various forms of thoracic sepsis and a variety of other conditions which fall outside the remit of other surgical specialties.

The following procedures should be part of the clinical and surgical provision from a thoracic surgical team:

- Resection, repair, reconstruction and diagnosis of the lung for benign or malignant disease or injury (includes primary and metastatic lung cancer).
- Procedures to manage diseases of the pleura and pleural space problems, including management of primary (mesothelioma) or secondary pleural neoplasms, pleural effusion, pneumothorax and thoracic empyema.
- Operations for chest wall and pleural space pathologies, including diagnosis, resection and reconstruction for neoplasms, infections or necrosis, repair of chest wall deformities (pectus deformities), as well as the management of traumatic chest wall disorders with or without instability.
- Surgical procedures of the mediastinum, including biopsy of mediastinal lymph nodes and resection of neoplasms and cysts, drainage of infections, mediastinal lymphadenectomy, mediastinotomy, mediastinoscopy and other video-assisted or open mediastinal approaches.
- Resection, reconstruction and drainage of the pericardium.
- Diagnostic and therapeutic endoscopic procedures using both the flexible and rigid scopes and instrumentation of the tracheobronchial tree and assisted by image guided means.

- Surgery of the thoracic sympathetic nerves.
- Surgical procedures of the diaphragm.
- Operations to provide thoracic exposure for interventions to be performed by allied specialists (i.e. cardiovascular, neurosurgeons, orthopaedics, invasive radiologists, general surgery.).
- Functional interventional procedures to manage emphysema.
- Surgery for traumatic injuries of the chest or organs within the chest.
- Operations to the thyroid gland in case of intrathoracic lesion (retrosternal goitre or cancer) as joint cases with ENT.
- Providing thoracic tissue samples for diagnosis by surgical means within the frame of inter-specialty commitments whenever less aggressive methods failed.
- Management of the surgical and non-surgical complications of the procedures listed above.
- Minimally invasive approaches (Video Assisted Thoracoscopic Surgery [VATS]/Robotic Surgery[1]) to the mediastinum, lung and chest wall.
- Ability for postoperative care and management of complications consequent to the above-mentioned surgical procedures.

The thoracic surgical team should have the ability to discuss indications, contraindications operability/resectability and prognosis of the above-mentioned surgical procedures within multidisciplinary teams. These MDT teams include:

- Lung cancer MDT
- Mesothelioma MDT
- Interstitial Lung Disease MDT
- Emphysema/COPD MDT
- Colorectal MDT
- Sarcoma MDT
- Complex cases MDT

1.2 Epidemiology

The largest single disease requiring management by thoracic surgery is primary lung cancer. There are two types of lung cancer: Non-Small Cell Lung Cancer (NSCLC), which accounts for approximately 85% of lung cancers, and Small Cell Lung Cancer (SCLC) which accounts for approximately 15%[2].

[1] At the present time, Health Technology Wales' guidance with regard to robot assisted thoracic surgery is that there is currently insufficient evidence to support routine adoption. It is therefore not currently commissioned by WHSSC. This position will be reviewed as the evidence base develops and further guidance is published.
[2] Macmillan Cancer UK

There are three common sub-types of NSCLC:

- squamous cell carcinoma
- large cell carcinoma
- adenocarcinoma.

Lung cancer is the third most common cancer in Wales by number of newly diagnosed cases per annum. While incidence in men is decreasing, it is increasing in women. Overall incidence of lung cancer is decreasing.[2]

Lung cancer has the widest absolute inequalities in incidence of any cancer in Wales. The most deprived fifth of the population has more than two and a halve times the incidence in the least deprived. The highest overall incidence rate has been in Cwm Taf Morgannwg UHB which is two-thirds higher than the lowest in Powys. Geographical differences in lung cancer across Wales are primarily due to historic trends in smoking and exposure to tobacco smoke, especially in areas of deprivation.[3]

Outcomes

Primary lung cancer related to tobacco is the commonest cause of cancer death in Wales. Lung cancer has the highest absolute number of deaths and highest mortality rate of any cancer in Wales. Lung cancer mortality rates are also highly unequal across socio-economic groups: mortality rates in the most deprived fifth are nearly 3 times greater than in the least deprived. Surgery is known to provide the best chance of survival.

However, patients often present with advanced disease making surgery less likely to be suitable or successful. During 2012-2016 in Wales, nearly half of the diagnosed lung cancers were diagnosed at stage 4. It is therefore essential that cases are detected early in order to provide the best prognosis[2].

Although survival has been improving, Wales has poor survival rates for lung cancer when compared with to other parts of the UK and many European countries.

Treatment Rates

While the lung cancer resection rate in Wales is equivalent to average UK rates, the annual National Lung Cancer Audit has shown that there is wide variation in surgical resection rates across the UK. Rates in Wales are lower than in the best performing areas of the UK and in comparison with the best performing European countries. The resection rate in Wales will need to increase further in order to improve lung cancer survival in Wales.

[3] http://www.wcisu.wales.nhs.uk/cancer-incidence-in-wales

Non-malignant disease

South Wales has a legacy of heavy industry and coal mining both of which contribute significantly to lung disease. In addition to the treatment of lung cancer, there are many other conditions which require thoracic surgery. These include other types of thoracic malignancies, pneumothorax, various forms of thoracic sepsis and a large group of other conditions of the chest.

It is recognised that there is unmet need in Wales for thoracic surgery to treat non-malignant conditions. The need to prioritise capacity for lung cancer has meant that patients with other conditions are often managed medically when they might benefit from a surgical procedure to treat their condition.

1.3 Aims and Objectives

The aim of this service specification is to define the requirements and standard of care essential for delivering thoracic surgery for people with diseases of the chest.

The objectives of this service specification are to:

- details the specifications required to deliver thoracic surgery services for people who are residents in Wales
- ensure minimum standards of care are met for the use of thoracic surgery
- ensure equitable access to thoracic surgery
- identify centres that are able to provide thoracic surgery for Welsh patients
- improve outcomes for people accessing thoracic surgery services.

1.4 Relationship with other documents

This document should be read in conjunction with the following documents:

- **NHS Wales**
  - All Wales Policy: Making Decisions in Individual Patient Funding requests (IPFR).

- **WHSSC policies and service specifications**
  - WHSSC Commissioning policy: Positron Emission Tomography (PET), CP50a (2019).
  - WHSSC Commissioning policy: Stereotactic Ablative Body Radiotherapy (SABR) for the Management of Surgically Inoperable Non-Small Cell Lung Cancer in Adults, CP76, (2014).

- **National Institute of Health and Care Excellence (NICE) guidance**
  - Improving Supportive and Palliative Care for adults with cancer, NICE Cancer Service Guidance (CGG4) March 2004
  - Lung Cancer: Diagnosis and management, NICE Guideline (NG122), March 2019
  - Suspected Cancer: Recognition and referral, NICE Guideline (NG12) July 2017
  - End of Life Care for Adults: service delivery, NICE Guideline (NG142), October 2019
  - Lung Cancer in Adults, NICE Quality Standard (QS17), December 2019
  - End of life care for adults, NICE Quality Standard (QS13) March 2017

- **Relevant NHS England policies**
  - Thoracic Surgery – Adults, NHS England Service Specification (170016/S), July 2017

2. Service Delivery

The Welsh Health Specialised Services Committee will commission the service of thoracic surgery for adults in Wales with conditions affecting the chest in-line with the quality standards identified in this specification.

2.1 Service description

In addition to the standards required within the Contract, specific quality standards and measures will be expected. The provider must also meet the standards as set out below.

Facilities and equipment

- The thoracic surgery service will have the following designated resources:
    - Dedicated thoracic surgery ward beds
    - Dedicated thoracic surgery theatre/s
    - Dedicated thoracic surgery recovery beds, HDU (level 2) and access to ITU (level 3).
- Patients will be assessed for their suitability for thoracic surgery, and will receive pre-operative/pre-admission assessment and post-operative follow up, in dedicated thoracic surgery clinics.
- Where possible this should be arranged in outreach clinics in the hospitals served by the regional thoracic unit for the convenience of patients and to ensure full access to the thoracic surgical service.
- Dedicated thoracic theatre sessions with at least one whole-day list per week per surgeon. Anything less than this would mean that it would be impossible for surgeons to provide sufficient level of activity for their employing Health Board/Trust to be assured of their competencies.

Specialist Team

The thoracic surgery service will consist of the following specialist team:

- Consultant-led care by general thoracic surgeons.
- Cardiothoracic Surgical trainees (ST1-3); thoracic sub-specialised surgical trainees (ST4-8) with on on-call cover from cardiac sub-specialised trainees (ST4-8).[4]
- Non training middle grade doctors and advanced care practitioners (surgical assistants).
- Consultant anaesthetists with specialist thoracic expertise.

[4] Cardiothoracic Surgery Workforce Report 2019, Society for Cardiothoracic Surgery in Great Britain and Ireland.

- Theatre staff with thoracic expertise.
- Specialist ward and HDU nurses with thoracic expertise.
- Thoracic nurse specialist support in all areas.
- Lung cancer nurse specialist support in thoracic surgical clinics and wards.
- Specialised thoracic physiotherapy, occupational therapy, dietetics, speech and language therapy and psychology (including out of hours and at weekends as necessary).
- Specialist support in post-operative pain control.
- Access to specialist palliative care.
- A designated team of pathologists with specialist thoracic expertise including the ability to interpret molecular markers for precision medicine.
- Designated administrative staff to ensure all clinical staff are supported in the timely delivery and monitoring of the service.
- Case managers.
- Respiratory care team with specialist interventionalist expertise.
- A designated team of radiologists with specialist thoracic expertise.
- Pharmacy support.

Organisation

- Thoracic Surgery should be identified as a separate service line within the hospital's directorate management structure.

Lung Cancer Multi-Disciplinary Team Meetings

- Thoracic surgeons are core members of the Lung Cancer MDT. All patients referred to thoracic surgery for further assessment of suitability for surgical resection of lung cancer must be referred through the Lung Cancer MDT.
- The thoracic surgery service will ensure that thoracic surgeons' job plans include sufficient allocation for Lung Cancer MDT meetings, including cross cover for annual leave, study leave or sickness. While surgeon attendance at the MDT in person is desirable, video conference linkage from the surgeon's base hospital is an acceptable alternative. The job plan of the surgeons include sufficient time for travel to and attendance at the lung cancer MDTs in their region.
- For those hospitals without on-site thoracic surgery it is essential that the populations they serve are not disadvantaged in any way. Those hospitals should have nominated surgeons working in the regional centres, such that thoracic surgical expertise can be accessed throughout the working week.

- MDTs should have in place access to the full range of radiology facilities and the technology to facilitate the electronic transfer of images between the referring hospital and the thoracic surgery centre.
- MDTs should have a clinical grade microscope with video camera for projecting histopathology images for discussion.

Other MDTs

Thoracic surgeons may also participate in a number of other MDTs, including:

- Mesothelioma MDT
- Interstitial Lung Disease MDT
- Emphysema/COPD MDT
- Colorectal MDT
- Sarcoma MDT[5]
- Complex cases MDT

Complex Cases MDT

- Complex patients should be discussed in a weekly complex cases MDT including as a minimum representation from thoracic surgery and anaesthetics. Wider membership may also include radiology, pathology and pre/rehabilitation.
- The complex cases MDT will provide multidisciplinary team opinion on surgical treatment.
- The complex cases MDT will provide a second opinion for patients with:
  - borderline resectability and acceptable fitness for surgery, and not initially accepted for surgery
  - a resectable lung cancer who are of borderline fitness and not initially accepted for surgery.

Prehabilitation and Enhanced Recovery

- Prehabilitation is a service which aims to ensure patients are fit for radical treatment. Patients with lung cancer should have the opportunity for referral to a prehabilitation programme within their local health board in line with the National Optimal Pathway for lung cancer in Wales.

[5] See WHSSC service specification CP149 Soft Tissue Sarcoma.

- Patients with a resectable lung cancer who are not fit for surgery should be offered a prehabilitation programmeprior to referral to thoracic surgery.[6]
- The principle of co-production is important to the successful delivery of prehabilitation. Patients should be supported to understand their responsibilities for self-care and how prehabilitation, and other services, will support them.
- There should be clear pathways established in the thoracic surgery units to provide an enhanced recovery programme. Enhanced recovery programmes are supported by a multi-disciplinary team including physiotherapy, occupational therapy, dietetics and nursing staff.
- Enhanced recovery pathways enable patients to recover at a faster pace from major surgery and should be adopted by the thoracic surgery centre.
- Each patient should have their multi-professional rehabilitation needs considered before, during and after treatment. These include nutrition, physical and emotional needs. Referral to local Allied Health Professionals (AHP) services should be made in a timely manner in order to meet these needs. This complies with the National Rehabilitation Standards for Wales.

Emergency provision

- The surgeons on the rota should be able to deal with the full range of thoracic emergencies.
- A dedicated, properly equipped and suitably staffed emergency theatre. The theatre staff, including anaesthetist and their OPDs, should have the necessary training and experience in thoracic surgery as a mandatory requirement.
- Non trauma thoracic emergencies and out of hours service
    - The service will provide 24/7 emergency cover by general thoracic surgical consultants (with or without mixed-practice cardiothoracic surgical colleagues). This may be delivered with support from surgical trainees, non-training middle grade doctors and appropriately trained advanced care practitioners.
    - Cross cover of rotas from consultants with a purely cardiac practice or from consultants from other specialities is unacceptable.

[6] While this is particularly for patients who are of borderline fitness for surgery, there is also evidence that some patients who are not of borderline fitness may become eligible for surgery following a prehabilitation programme (citation required). Criteria for access to prehabilitation programmes are the remit of health boards as the responsible commissioners and providers of this service.

    - The service will ensure that there is 24/7 cover of thoracic surgical inpatients.
    - A sustainable on call rota should not be more frequent than 1 in 4.
    - The service will ensure there is 24/7 physiotherapy cover to support any inpatient respiratory emergencies.
- Trauma (inc. major trauma) thoracic emergencies:
    - The thoracic surgery service will provide advice and support to trauma and major trauma services in accordance with locally agreed protocols.
    - This support with be in alignment with the expectations and guidance set out the Society for Cardiothoracic Surgery position statement on trauma[7].

Education, training and research

- Providers of thoracic surgery should be linked to a University.
- Providers are expected to offer programmes for ongoing education and development for all professionals involved in the service.
- Patents should be given the opportunity to enter approved clinical trials for which they fulfil the entry criteria.
- There should be an ongoing programme for research activity in line with European Guidelines[8] for a clinical research programme within a general thoracic surgery unit.

Referral Links for patient support

- There should be close links with support services such as social workers, psychiatrists, chaplain, bereavement support and the primary health care team.

Patient Information

- Patients should be provided with information about their condition, about thoracic surgery and treatment process, so they are informed on what to expect from the service.
- Patients should be provided with contact details (including named person/s to contact) should they need to communicate with the service.

[7] Provision of Cardiothoracic Surgery Cover for Trauma in United Kingdom and Ireland. Society for Cardiothoracic Surgery in Great Britain and Ireland (2020).
[8] Alessandro Brunellia, Pierre Emmanuel Falcoz et al. European guidelines on structure and qualification of general thoracic surgery. European Journal of Cardio-Thoracic Surgery. 2014: 45(2014);779–786.

2.2 Interdependencies with other services or providers

The thoracic surgery service must have access to the following services. It is anticipated these services will be co-located with the thoracic surgery service:

- Respiratory medicine
- Haematological biochemical and microbiological laboratories
- Respiratory pathology laboratory
- Endoscopic examinations by bronchoscopy and oesophagoscopy (including endobronchial ultrasound and endoscopic ultrasound)
- Radiological investigation by plain X-ray, contrast studies, ultrasound needle biopsy, vascular imaging, computed tomography (including PET CT) and other specialist diagnostics.
- Support from the full range of specialist thoracic pathology services
- Support from all other hospital services especially interventional radiology and pulmonary rehabilitation.
- Dedicated dietetics, physiotherapy, occupational therapy, speech and language therapy, and pain management to deliver multimodal pre/rehabilitation.
- Pharmacy
- Cardiac surgery:
    - Cardiothoracic trainees: Trainees are shared with cardiac surgery up to ST3. From ST4 to ST8, trainees specialise in either thoracic or cardiac surgery (but are still required to cover emergencies in both disciplines). The thoracic surgery service will therefore require a close working relationship with cardiac surgery with regard to training. It is recognised that in the long run, training requirements and the relationship between the two specialties may change.
    - Anaesthetics and theatre nursing: it may be appropriate to share anaesthetics and nursing skills and expertise across thoracic and cardiac surgery to provide operational efficiencies and service resilience. It is recognised the extent to which thoracic and cardiac surgery services benefit from sharing staff with these skills will vary across providers.
- Intensive care: Occasionally thoracic surgery patients may require ITU while still under the care of the thoracic surgery service. This may be provided via cardiac or general ITU.
- In addition to these collocated services, a proportion of patients will require access to the Non Emergency Patient Transport service provided by Wales Ambulance Service Trust.

2.3 Acceptance Criteria

The service outlined in this specification is for patients ordinarily resident in Wales, or otherwise the commissioning responsibility of the NHS in Wales. This excludes patients who whilst resident in Wales, are registered with a GP practice in England, but includes patients resident in England who are registered with a GP Practice in Wales.

2.4 Patient Pathway (Annex i)

Referral

- Patients usually access thoracic surgery as a tertiary service via referrals from respiratory physicians and other hospital consultants. A small proportion are referred to the service directly from primary care, or as emergencies via A & E departments especially following trauma.
- Referrals to thoracic surgery for patients with primary lung cancer are agreed by the lung cancer MDT. Referrals for other conditions may also be via the relevant MDT. Patients admitted under respiratory medicine with acute conditions requiring urgent treatment are referred urgently as inter-hospital transfers.

Out-patients and pre-admission assessment

- Out-patient appointments should be provided as locally as possible to the patient. Pre-admission assessment may take place at the thoracic surgery centre or locally if suitable arrangements can be put in place, and should include an anaesthetic review.

Discharge

- If, once any thoracic surgery related complications have been addressed, patients require on going hospital care, they should be repatriated to a local DGH hospital for further management.

Follow up

- Patients should be offered a specialist follow up appointment within 6 weeks of surgery (oncological patients should be re-discussed at MDT within 4 weeks post surgery) and regular specialist follow up thereafter, which may be delivered within a local setting and include a protocol led clinical nurse specialist follow up.
- A system of follow up appointments at outpatient and peripheral clinics should be in place.
- There should be rapid and comprehensive feedback to referral teams including the patients GP to ensure that as much follow up care as possible can be provided locally.
- Where a patients has on going rehabilitation needs, these should be met locally.

- There should be an agreed referral process back to the centre for patients requiring specialist advice or support. Urgent cases should be on an immediate basis. Failure to attend an appointment without explanation should be followed up.

Holistic Needs Assessment

- As recommended by NICE guidelines, patients with lung cancer should be offered a holistic needs assessment at each key stage of care that informs their care plan and the need for referral to specialist services. The holistic needs assessment is usually carried out by the clinical nurse specialist.

Palliative Care

- All services caring for patients with progressive life threatening disease have a responsibility to provide care with a palliative approach.
- All patients should have access to specialist palliative care services as described in the CSCG Minimum Standards for Specialist Palliative Care (NHS Wales 2005)[9].

2.5 Service provider/Designated Centre

- University Hospital of Wales
  Cardiff & Vale University Health Board
  Heath Park
  Cardiff
  CF14 4XW

- Morriston Hospital
  Swansea Bay University Health Board
  Heol Maes Eglwys
  Morriston
  SA6 6NL

- Liverpool Heart and Chest Hospital NHS Foundation Trust
  Thomas Drive
  Liverpool
  L14 3PE

- Royal Stoke University Hospital
  University Hospitals of North Midlands NHS Trust
  Newcastle Road
  Stoke-on-Trent
  Staffordshire

[9] http://www.wales.nhs.uk/sites3/Documents/322/National_Standards_for_Specialist_Palliative_Care_for_Cancer_2005_English.pdf

ST4 6QG

- Heart of England NHS Foundation Trust
  Bordesley Green East
  Birmingham
  B9 5SS

2.6 Exceptions

If the patient does not meet the criteria for treatment as outlined in this policy, an Individual Patient Funding Request (IPFR) can be submitted for consideration in line with the All Wales Policy: Making Decisions on Individual Patient Funding Requests. The request will then be considered by the All Wales IPFR Panel.

If the patient wishes to be referred to a provider outside of the agreed pathway, and IPFR should be submitted.

Further information on making IPFR requests can be found at: Welsh Health Specialised Services Committee (WHSSC) | Individual Patient Funding Requests

3. Quality and Patient Safety

The provider must work to written quality standard and provide monitoring information to the lead commissioner. The quality management systems must be externally audited and accredited.

The centre must enable the patients, carers and advocates informed participation and to be able to demonstrate this. Provision should be made for patients with communication difficulties.

3.1 Quality Indicators (Standards)

- Thoracic surgery must be performed by qualified surgeons who have full GMC Registration with a licence to practice, and specialised in general thoracic surgery in accordance with National and European regulations.

- A surgeon practising in thoracic surgery must have extensive and updated knowledge of all aspects of pathophysiology, epidemiology, diagnosis, perioperative, intraoperative and postoperative care of patients with surgical disease of the chest.

Minimum volumes

- The thoracic surgery unit should undertake a minimum of 150 primary lung resections per year.
- The thoracic surgery unit should have a minimum of 3 full time general thoracic surgeons.

The following targets should be achieved:

- Cancer waiting time targets[10]
    - Urgent Suspected Cancer: treatment within 62 days of referral from Primary Care.
    - Non Urgent Suspected Cancer: treatment within 31 days of the decision to treat.
- The results of frozen section analysis of intra-operative specimens should be communicated to the operating surgeon within 1 hour of the sample being taken.
- Urgent (non cancer) in-patient treatment:
    - Indications for urgent treatment (such as empyema or pneumothorax) often requiring in-patient transfer from General Hospitals to the thoracic surgery unit:
    - Transfer to the thoracic surgery unit and treatment within 48 hours of referral.

[10] NHS Wales is replacing these targets with the Single Cancer Pathway (a target of 62 days from the point of suspicion). Also see 4.2 Key Performance Indicators.

- Patients with non malignant conditions on elective referral pathways should be treated within the referral to treatment targets for Wales:
    - 95% within 26 weeks from GP referral to treatment
    - No patient should wait in excess of 36 weeks from referral to treatment.
- Where there is a clinical suspicion of malignancy, patients referred for a diagnostic biopsy of lung or mediastinal lymph node should have this performed within a clinically appropriate timeframe. The time from referral for diagnostic biopsy to performing the biopsy for these patients will form part of the performance monitoring of the service.

3.2 National Standards

The service must measure and report outcomes specified by the Society for Cardiothoracic Surgeons for submission to the SCTS Thoracic Surgical Database:

- Post operative mortality
- Post operative complications
- Air leak after lung resection for primary cancer
- Return to theatre
- ITU readmission
- Need for ventilation

Surgeons' appraisals should include specific reference to thoracic outcomes and activities.

3.3 Other quality requirements

- the provider will have a recognised system to demonstrate service quality and standards
- the service will have detailed clinical protocols setting out nationally (and local where appropriate) recognised good practice for each treatment site
- the quality system and its treatment protocols will be subject to regular clinical and management audit
- the provider is required to undertake regular patient surveys and develop and implement an action plan based on findings

4. Performance monitoring and Information Requirement

4.1 Performance Monitoring

WHSSC will be responsible for commissioning services in line with this policy. This will include agreeing appropriate information and procedures to monitor the performance of organisations.

For the services defined in this policy the following approach will be adopted:

- Service providers to evidence quality and performance controls
- Service providers to evidence compliance with standards of care

WHSSC will conduct performance and quality reviews on an annual basis

4.2 Key Performance Indicators

The providers will be expected to monitor against the full list of Quality Indicators derived from the service description components described in Section 2.1.

The provider should also monitor the appropriateness of referrals into the service and provide regular feedback to referrers on inappropriate referrals, identifying any trends or potential educational needs.

In particular, the provider will be expected to monitor against the following target outcomes:

- Cancer Waiting Times - National Optimum Pathway and the Single Cancer Pathway
- Referral to Treatment waiting times
- Thoracic surgery component waiting times for patients on cancer and elective pathways.
- Urgent treatment/transfer times (non cancer indications)
- Resection rates by MDT
- Thoracic surgeon attendance at Lung Cancer MDT
- Intra-operative pathology findings and advice
- Length of stay for patients having lung surgery – cancer and non-cancer
- Prehabilitation and rehabilitation key performance indicators and outcomes

In addition, thoracic surgery services should have systems in place to routinely collect patient reported experience and outcome measures for all patients.

These KPIs are in addition to performance and quality reporting requirements specified in WHSSC contracts with providers of thoracic surgery

4.3 .Date of Review

This document is scheduled for review by September 2022, where we will check if any new evidence is available.

If an update is carried out the policy will remain extant until the revised policy is published.

5. Equality Impact and Assessment

The Equality Impact Assessment (EQIA) process has been developed to help promote fair and equal treatment in the delivery of health services. It aims to enable Welsh Health Specialised Services Committee to identify and eliminate detrimental treatment caused by the adverse impact of health service policies upon groups and individuals for reasons of race, gender re-assignment, disability, sex, sexual orientation, age, religion and belief, marriage and civil partnership, pregnancy and maternity and language (Welsh).

This policy has been subjected to an Equality Impact Assessment.

The Assessment demonstrates the policy is robust and there is no potential for discrimination or adverse impact. All opportunities to promote equality have been taken.

6. Putting Things Right

6.1 Raising a Concern

Whilst every effort has been made to ensure that decisions made under this policy are robust and appropriate for the patient group, it is acknowledged that there may be occasions when the patient or their representative are not happy with decisions made or the treatment provided.

The patient or their representative should be guided by the clinician, or the member of NHS staff with whom the concern is raised, to the appropriate arrangements for management of their concern.

If a patient or their representative is unhappy with the care provided during the treatment or the clinical decision to withdraw treatment provided under this policy, the patient and/or their representative should be guided to the LHB for NHS Putting Things Right. For services provided outside NHS Wales the patient or their representative should be guided to the NHS Trust Concerns Procedure, with a copy of the concern being sent to WHSSC.

6.2 Individual Patient Funding Request (IPFR)

If the patient does not meet the criteria for treatment as outlined in this policy, an Individual Patient Funding Request (IPFR) can be submitted for consideration in line with the All Wales Policy: Making Decisions on Individual Patient Funding Requests. The request will then be considered by the All Wales IPFR Panel.

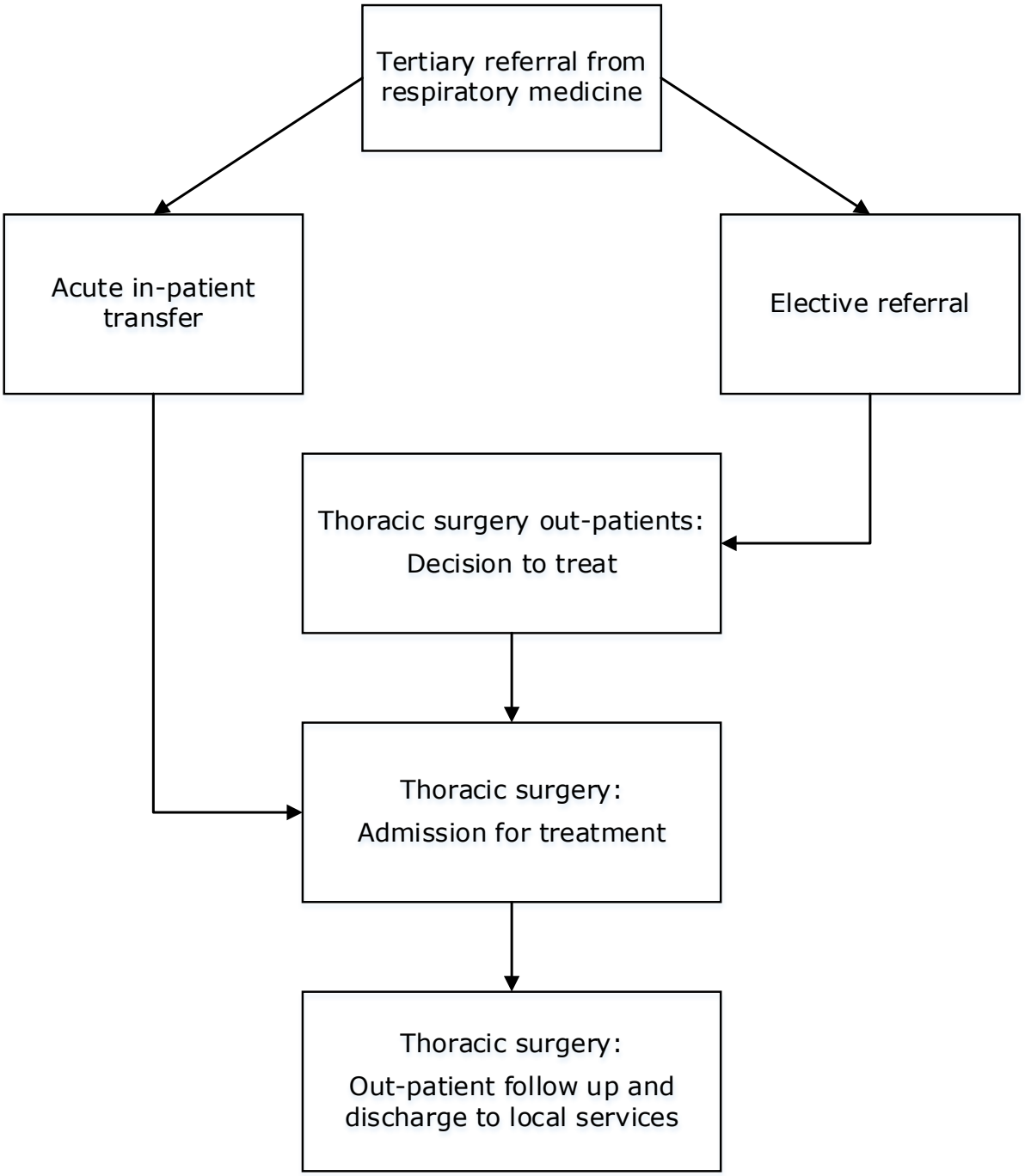
If an IPFR is declined by the Panel, a patient and/or their NHS clinician has the right to request information about how the decision was reached. If the patient and their NHS clinician feel the process has not been followed in accordance with this policy, arrangements can be made for an independent review of the process to be undertaken by the patient's Local Health Board. The ground for the review, which are detailed in the All Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR), must be clearly stated

If the patient wishes to be referred to a provider outside of the agreed pathway, and IPFR should be submitted.

Further information on making IPFR requests can be found at: Welsh Health Specialised Services Committee (WHSSC) | Individual Patient Funding Requests

Annex i Patient Pathway

For suspected lung cancer, see the national optimal pathway for lung cancer.



Annex ii Codes

Code Category	Code	Description
OPCS	173	Thoracic surgery specialty code