GIG CYMRU NHS WALES
Cyd-bwyllgor Comisiynu
Joint Commissioning Committee

Adult Thoracic Surgery

Service Specification: SS144

Document Information	
Document Name	Adult Thoracic Surgery
Document No	SS144
Document Purpose	Service Specification
Publication Date	January 2026
Version No	3.0
Commissioning Team Author	Cancer and Blood
Target Audience	Chief Executives, Medical Directors, Directors of Finance, Directors of Therapies, Thoracic Surgeons, Respiratory Medicine, Cardiac Services, Cardiothoracic Surgery, Acute Medicine, South Wales Lung Cancer MDT Leads, Liverpool Heart and Chest NHS Foundation Trust, Royal Stoke University Hospital, Heart of England NHS Foundation Trust
Description	NHS Wales will routinely commission this specialised service in accordance with the criteria described in this policy
Document Update Information	Updates to reference documents.

Contents

Abbreviations

AWMSG	All Wales Medicines Strategy Group
IPFR	Individual Patient Funding Request
NWJCC	NHS Wales Joint Commissioning Committee

Statement

NHS Wales Joint Commissioning Committee (NWJCC) will commission the service of adult thoracic surgery in accordance with the criteria outlined in this specification.

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

Welsh Language

NWJCC is committed to treating the English and Welsh languages on the basis of equality, and endeavour to ensure commissioned services meet the requirements of the legislative framework for Welsh Language, including the Welsh Language Act (1993), the Welsh Language (Wales) Measure 2011 and the Welsh Language Standards (No.7) Regulations 2018.

Where a service is provided in a private facility or in a hospital outside of Wales, the provisions of the Welsh language standards do not directly apply but in recognition of its importance to the patient experience, the referring health board should ensure that wherever possible patients have access to their preferred language.

In order to facilitate this, NWJCC is committed to working closely with providers to ensure that in the absence of a Welsh speaker, written information will be offered and people have access to either a translator or 'Language-line' if requested. Where possible, links to local teams should be maintained during the period of care.

Decarbonisation

NWJCC is committed to taking assertive action to reducing the carbon footprint through mindful commissioning activities. Where possible and taking into account each individual patient's needs, services are provided closer to home, including via digital and virtual access, with a delivery chain for service provision and associated capital that reflects the NWJCC commitment.

Disclaimer

NWJCC assumes that healthcare professionals will use their clinical judgement, 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, or Local Authority.

NWJCC disclaims any responsibility for damages arising out of the use or non-use of this policy.

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 NHS Wales Joint Commissioning Committee (NWJCC) 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 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 (including navigational bronchoscopy particularly for biopsy of small lung nodules).
- 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) 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%[1].

There are three common sub-types of NSCLC:

- squamous cell carcinoma
- large cell carcinoma
- adenocarcinoma.

[1] Macmillan Cancer UK

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 half 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 2023 in Wales, 45% of the diagnosed lung cancers were diagnosed at stage 4[4]. It is therefore essential that cases are detected early in order to provide the best prognosis[5]. 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.

In June 2025, Welsh Government announced that a national lung cancer screening programme will be implemented in Wales. Evidence shows that the introduction of screening will shift detection towards earlier stages of disease, increasing the number of patients suitable for surgery and improving survival. It is anticipated the programme will start screening patients in 2027.

Treatment Rates

While the lung cancer resection rate in Wales meets the National Lung Cancer Audit (NLCA) target rate of 17% in 2023, and has improved in recent years (up from 14% in 2022), this rate is below the average rate in England (20%). The resection rate in Wales will need to increase further in order to improve lung cancer survival in Wales.

[2] Macmillan Cancer UK
[3] http://www.wcisu.wales.nhs.uk/cancer-incidence-in-wales
[4] National Lung Cancer Audit State of the Nation 2025: An audit of care received by people diagnosed with lung cancer in England and Wales during 2023
[5] Macmillan Cancer UK

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:

- detail the specifications required to deliver thoracic surgery services for people who are resident in Wales
- ensure minimum standards of care are set 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)
  - National Optimal Lung Cancer Pathway (Wales National Cancer Team)

- **NHS Wales Joint Commissioning Committee policies and service specifications**
  - NWJCC Commissioning policy: Positron Emission Tomography (PET), CP50 (2025)
  - NWJCC Commissioning policy: Stereotactic Ablative Body Radiotherapy (SABR) for the Management of Surgically Inoperable Non-Small Cell Lung Cancer in Adults, CP76, (2023)

- Major Trauma Centre service specification

- **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, updated March 2024
  - Suspected Cancer: Recognition and referral, NICE Guideline (NG12) July 2017, updated May 2025
  - End of Life Care for Adults: service delivery, NICE Guideline (NG142), October 2019
  - Lung Cancer in Adults, NICE Quality Standard (QS17), March 2012, updated December 2019
  - End of life care for adults, NICE Quality Standard (QS13) November 2011, updated September 2021

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

- **Other publications**
  - Lung Cancer - Getting It Right First Time (GIRFT) National Specialty Report (2021)
  - Roberts ME, Rahman NM, Maskell NA On behalf of the BTS Pleural Guideline Development Group*, et al* British Thoracic Society Guideline for pleural disease *Thorax* 2023;78:s1-s42.
  - Batchelor TJP, Rasburn NJ, Abdelnour-Berchtold E, Brunelli A, Cerfolio RJ, Gonzalez M et al. Guidelines for enhanced recovery after lung surgery: recommendations of the Enhanced Recovery After Surgery (ERASVR) Society and the European Society of Thoracic Surgeons (ESTS). Eur J Cardiothorac Surg 2019;55:91–115

2. Service Delivery

The NHS Wales Joint Commissioning Committee will commission the service of thoracic surgery for adults in Wales with conditions affecting the chest, in line with the criteria 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)[6]
- Non training middle grade doctors and advanced care practitioners (surgical assistants)
- Consultant anaesthetists with specialist thoracic expertise
- Theatre staff with thoracic expertise
- Specialist ward and HDU nurses with thoracic expertise

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

- 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.
- There should be a dedicated responsible surgeon for each MDT (supported by a second surgeon in order to have a second opinion and to provide cover)
- 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 should 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
- Complex Cases MDT

Complex Cases MDT[7]

- 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. All thoracic patients should have the opportunity for referral to a prehabilitation programme within their local health board and for lung cancer patients in line with the National Optimal Pathway for lung cancer in Wales.

[7] Lung Cancer – GIRFT 2021. "Every surgical unit should have a high risk MDT to ensure improved access to surgery for borderline fitness patients and to improve radical treatment."

- Patients with a resectable lung cancer who are not fit for surgery should be offered a prehabilitation programme prior to referral to thoracic surgery[8,9].
- 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.
  - The service will ensure that there is 24/7 cover of thoracic surgical inpatients.

[8] 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:
- Man W, Chaplin E, Daynes E, et al. Thorax 2023;78 (suppl 5):2–15;
- Chronic obstructive pulmonary disease in over 16s: diagnosis and management NG115 July 2019;
- Batchelor TJP, Rasburn NJ, Abdelnour-Berchtold E, Brunelli A, Cerfolio RJ, Gonzalez M et al. Guidelines for enhanced recovery after lung surgery: recommendations of the Enhanced Recovery After Surgery (ERASVR) Society and the European Society of Thoracic Surgeons (ESTS). Eur J Cardiothorac Surg 2019;55:91–115.)

[9] Criteria for access to prehabilitation programmes are the remit of health boards as the responsible commissioners and providers of this service.

  - 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 (including 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 will be in alignment with the expectations and guidance set out by the Society for Cardiothoracic Surgery position statement on trauma[10].

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.
- Patients 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[11] 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.

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

[10] Provision of Cardiothoracic Surgery Cover for Trauma in United Kingdom and Ireland. Society for Cardiothoracic Surgery in Great Britain and Ireland (2020).
[11] 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.

- 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 patient 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)[12].

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
ST4 6QG

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

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

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, an IPFR should be submitted.

Further information on making IPFR requests can be found at: Individual Patient Funding Requests

3. Quality and Patient Safety

The provider must work to written quality standards 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)

- 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.

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

- Cancer Waiting Times - National Optimum Pathway for Lung Cancer
- Referral to Treatment waiting times for elective surgery
- 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.

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

NWJCC 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

NWJCC 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.

The following targets should be achieved:

- Compliance with the National Optimal Pathway for Lung Cancer:
  - Point of suspicion to surgery – 62 days
  - Decision to treat to surgery – 21 days
- 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.
- Patients with non-malignant conditions on elective referral pathways should be treated within the targets specified in the NHS Wales Performance Framework
- 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, in accordance with the National Optimal Cancer

Pathway for Lung Cancer. The time from referral for diagnostic biopsy to performing the biopsy for these patients will form part of the performance monitoring of the service.

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 NWJCC contracts with providers of thoracic surgery.

4.3 Date of Review

This document is scheduled for review every three years, unless information is received which indicates that the policy requires revision.

If an update is carried out, this version of the policy will remain extant until the revised policy is published.

5. Equality Impact and Assessment

The Equality Impact Assessment (EIA) process has been developed to help promote fair and equal treatment in the delivery of health services. It aims to enable NHS Wales Joint Commissioning 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 NWJCC.

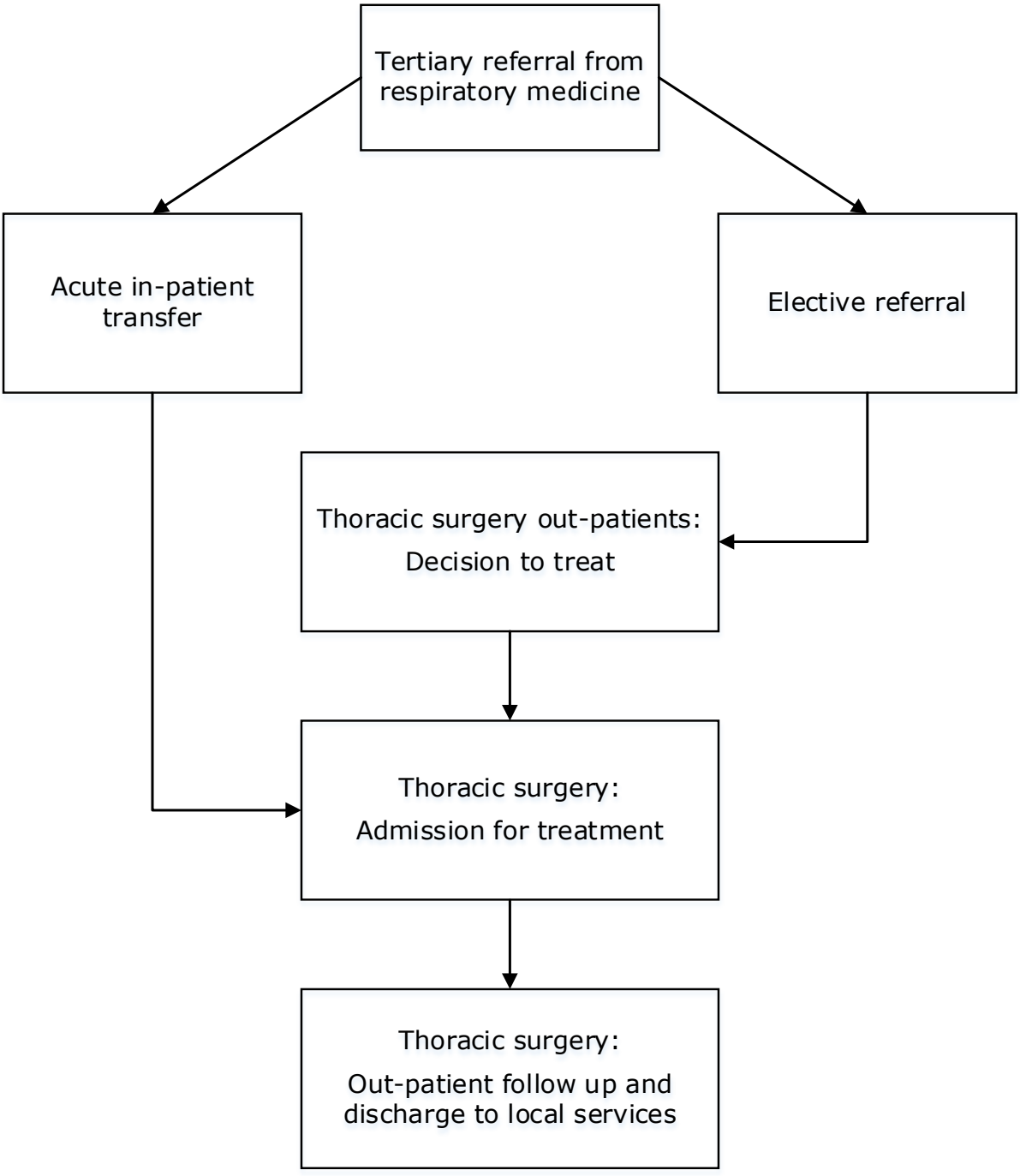
6.2 Individual Patient Funding Request (IPFR)

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.

Further information on making IPFR requests can be found at: Individual Patient Funding Requests.

Annex i Patient Pathway

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



Annex ii Codes

The list of ICD codes is indicative and is not exhaustive. Additional codes may be used for contract monitoring purposes, furthermore some codes may cover indications not included within this policy.

Code Category	Code	Description
OPCS	173	Thoracic surgery specialty code

Annex iii Glossary

Individual Patient Funding Request (IPFR)
An IPFR is a request to NHS Wales Joint Commissioning Committee (NWJCC) to fund an intervention, device or treatment for patients that fall outside the range of services and treatments routinely provided across Wales.

NHS Wales Joint Commissioning Committee (NWJCC)
NWJCC is a joint committee of the seven local health boards in Wales. The purpose of NWJCC is to ensure that the population of Wales has fair and equitable access to the full range of Tertiary Services. NWJCC ensures that services within our portfolio are commissioned from providers that have the appropriate experience and expertise. They ensure that these providers are able to provide a robust, high quality and sustainable services, which are safe for patients and are cost effective for NHS Wales.

Contact Us

If you have a question related to this document you can contact us using one of the methods outlined below.

If you would like this document in an alternative format and/or language, please contact us for assistance.

Email:

NWJCC consultation mailbox – nwjccconsultation@wales.nhs.uk

Telephone:

General Enquiries – 01443 433112

Website:

Contact us - NHS Wales Joint Commissioning Committee

Writing:

If you wish to contact the NHS Wales Joint Commissioning Committee, you can write to us at one of our locations below, we welcome correspondence in Welsh or English:

South Wales Offices
Unit 1, Charnwood Court, Heol Billingsley, Nantgarw, CF15 7QZ
Unit G1 The Willowford, Main Avenue, Treforest Industrial Estate, Pontypridd, CF37 5YL

North Wales Offices
Unit 3, Media Point - Unit 3, Mold Business Park, Mold, CH7 1XY
Preswylfa, Hendy Road, Mold, CH7 1PZ