**COMMISSIONING GUIDANCE FOR THE WHOLE LUNG CANCER PATHWAY**

**APPENDIX**

|  |  |
| --- | --- |
| **Commissioning guidance No** |  |
| **Service** | **Lung Cancer Whole Pathway**  **(including direct and specialised commissioning)** |
| **Commissioner Lead** |  |
| **Provider Lead** |  |
| **Period** | **2024/25** |
| **Date of Review** | **April 2025** |

|  |
| --- |
| 1. **Relevant standards summary with links**   A1.1 Early diagnosis (1.1.1)   1. **Public awareness**   Link to doc on early symptomatic diagnosis   1. **Recognition and referral**   Add NICE NG12 link   1. **Lung Cancer Screening**   Link to UKNSC and NHSE etc  A1.2 Reducing variation (1.1.2)   1. **Access to specialist care**   See Service specification for detail of personnel and services with recommended measures and standards.   1. **Diagnosis and staging**   Ensure that people with suspected lung cancer have diagnostic test(s) that provide the most diagnostic and staging information with least risk of harm to the patient.  Link to NICE NG122.   1. **Treatment with curative intent**   Commission services that ensure people with lung cancer have the best chance of being cured of their cancer by following NICE guidance:   * 1. For people with NSCLC who are well enough and for whom treatment with curative intent is suitable, offer lobectomy.   2. Offer more extensive surgery (bronchoangioplastic surgery, bilobectomy, pneumonectomy) only when needed to obtain clear margins.   3. Perform hilar and mediastinal lymph node sampling or en bloc resection for all people having surgery with curative intent.   4. For people with T3 NSCLC with chest wall involvement who are having surgery, aim for complete resection of the tumour using either extrapleural or en bloc chest wall resection.   5. For people with stage I–IIA (T1a–T2b, N0, M0) NSCLC who decline lobectomy or in whom it is contraindicated, offer radical radiotherapy with stereotactic ablative radiotherapy (SABR) or sublobar resection.   6. For people with stage I–IIA (T1a–T2b, N0, M0) NSCLC who decline surgery or in whom any surgery is contraindicated, offer SABR. If SABR is contraindicated, offer either conventional or hyperfractionated radiotherapy.   7. For eligible people with stage IIIA NSCLC who cannot tolerate or who decline chemoradiotherapy (with or without surgery), consider radical radiotherapy (either conventional or hyperfractionated).   8. For eligible people with stage IIIB NSCLC who cannot tolerate or who decline chemoradiotherapy, consider radical radiotherapy (either conventional or hyperfractionated).   NICE NG122: <https://www.nice.org.uk/guidance/ng122>  NB NICE updates treatment recommendations regularly and publishes summary pathways – see link.   1. **Treatment with palliative intent**   Commission services that ensure people with advanced lung cancer have the best chance of treatment that gives long term survival and maintains overall quality of life. Follow NICE guidance including regular updates to systemic anticancer therapy. Ensure access to those drugs only available through the Cancer Drugs Fund. Key recommendations include:   * 1. People with stage IIIB or IV non-small-cell lung cancer and eligible performance status are offered systemic therapy (first, maintenance, and second-line) in accordance with NICE guidance (including those therapies available through the Cancer Drugs Fund) that is tailored to the pathological and molecular sub-type of the tumour and individual predictive factors.   2. People with small-cell lung cancer have treatment initiated within 2 weeks of the pathological diagnosis in line with the NOLCP.   3. People with lung cancer have access to all appropriate palliative interventions delivered by expert clinicians and teams.   NG122: <https://www.nice.org.uk/guidance/ng122>  A1.3 Living with lung cancer (1.1.3)   1. **Supportive Care**   Commission services that ensure people have equity of access to care that improves aspects of living with cancer in line with the National Cancer Survivorship Initiative and underpinned with the Living With Cancer agenda, which advocates the need for personalised care. Key recommendations include.   * 1. People with known or suspected lung cancer have access to a named lung cancer clinical nurse specialist at all key points in the pathway and who they can contact between scheduled hospital visits.   2. People with lung cancer are offered an holistic needs assessment at each key stage of care that informs their care plan and the need for referral to other services.   3. People with lung cancer are offered a specialist follow-up appointment within 6 weeks of completing initial treatment and regular specialist follow-up thereafter, which can include protocol-led clinical nurse specialist follow-up.   4. People with lung cancer are offered care integrated across primary and secondary care with liaison coordinated through specialist nursing teams. Nurse led interventions provide psychological support, address information needs, reduce emotional distress at a difficult time for both patient and carer. If symptoms are managed this can enhance physical functioning.   5. Prehabilitation / habilitation/ rehabilitation to facilitate better outcomes from treatment and decrease morbidity.  1. Commission services that ensure people with stage IV (advanced, incurable disease), irrespective of other treatments offered, are also routinely offered a specialist palliative / enhanced supportive care assessment at the time of diagnosis to improve quality of life, reduce depression and improve satisfaction with care. 2. Commission services that ensure that people with known or suspected lung cancer have information about their disease and options for treatment presented to them in a format they can understand, to enable them to make an informed choice, and in line with NICE guidance.   See Link: [Personalised care | Healthcare professionals | Macmillan Cancer Support](https://www.macmillan.org.uk/healthcare-professionals/innovation-in-cancer-care/personalised-care)  See Link: <https://roycastle.org/about-lung-cancer/treatments/treatment-options/>   1. **Lung Cancer Nurse Specialists – justification for increased provision**   Lung cancer nurse specialists (LCNSs) are highly skilled professionals and key members of multi-disciplinary teams (MDTs). They provide high-quality, safety-critical, patient-centred, holistic care. The following section refers to LCNS that have responsibilities throughout the patient pathway. Numbers do not include nurses employed for a specific area of the pathway, which are additional.  **Rationale for one WTE LCNS per 40 new lung cancer patients per year**  The recommended LCNS / patient ratio was first established more than 15 years ago and no longer reflects the complex nature of the whole pathway, new technologies, increased treatment rates, greater access to research trials and better survival (1 year survival has improved from 31% to 45%).  LCNS have rapidly adapted service delivery to accommodate the continuous changes, but this has exposed inadequate capacity to support all patients throughout their pathway. The National Lung Cancer Audit report (2022) has set a benchmark that LCNS should meet at least 90% of patients with a suspected lung cancer. Recent years show compliance ranging from 60% to 80% between cancer networks.  Some key roles of LCNS are:   * NOLCP: requires increased LCNS availability and expert downstream knowledge of the pathway to educate and support patients to participate in their care, including participation in clinical trials. * NOLCP: Although a standardised process, patients arrive with human factors including social (deprivation) / symptom burden/ psychological issues which contribute to delays. LCNS proactively and compassionately address the issues, reducing and mitigating delays, crucial to patient outcomes and survival. * Managing the complex multi-modality treatment across specialities (surgery/medical oncology/clinical oncology). * LCNS are essential to proactive rapidly facilitating change in services e.g. implementation of liquid biopsy (ctDNA). * Providing expert knowledge on tests and treatment options and side effects. * Prehabilitation is rapidly becoming a part of LCNS role due to their unique position often meeting patients before a diagnosis is given.   Forty-five percent of patients remain on the LCNS case load beyond one year, so greater LCNS capacity is needed.  Thus, the number of patients on a LCNS case load needs to reflect the rapidly changing landscape of lung cancer patients’ experience and life expectancy. This variation across UK centres demonstrates a clear inequality for lung cancer patients:  For example, across 31 UK centres  11 have 1 WTE per <80 new patients per year  10 have 1 WTE per 80 new patients per year approx.  11 have 1 WTE per >80 new patients per year    **LCNS AFC band 7 and above rationale for 1 WTE per 80 new patients**  Lung Cancer Nursing UK (LCNUK) indicate that the advanced skills required in this complex role and the responsibilities taken on by at AFC band 7 post. They recommend that all nurses working at band 6 within a LCNS team should be supported to progress to a band 7 and above.  LCNS undertake leadership roles in service delivery, redesign, and improvement. They are well placed to identify where services can be adapted or introduced to better meet patients’ needs and efficiencies can be made. LCNUK have written a professional development framework to support commissioners / employers/ policy makers/ line managers to job match existing LCNS and support workforce planning in the future.  Other frameworks such as Aspirant Cancer Career and Education Development (ACCEND) programme can be used but are not as focused specifically on LCNS.  The LCNUK framework ‘Caring Crucial Complex’ was designed to align with the combined Nursing National job profiles.  Across the UK, of 31 centres looked at:   * 10 had one band 8 WTE LCNS * All 31 had one band 7 WTE LCNS * 18 had 2 or more WTE band 7 LCNS   Again, this variation across UK centres demonstrates a clear inequality for lung cancer patients.  Band 7 LCNS will have a significant proportion of their job taken up with people management whilst leading a service and being counted into their numbers as having a case load of 80 patients minimum, which they will not be able to manage, and their colleagues are likely to absorb. This reduces the time overall available for patients.  Evidence shows that patients have better outcomes if seen by a LCNS and are twice as likely to access some form of anti-cancer treatment if they have access to an LCNS coupled with band 7 nurses seeing more patients than band 6 nurses, it is important to harness every opportunity giving patients with lung cancer every advantage(1-3).  If services do not address the LCNS work force now, future lung cancer patients will see worse outcomes as the workforce will have to work to the constraints of their AFC banding and be limited by capacity. This will impact on innovative roles that include non-medical prescribing and IRMER training to order CT scans and CXRs, but also the leadership requirements to develop and undertake nurse led clinics. Furthermore, there will be issues with retention of highly qualified individuals.  Organising LCNS teams to a majority AFC band 7 creates an environment where innovation, leadership, financial savings and improvement can flourish to the benefit of the healthcare service and patient. |

|  |
| --- |
| **A2. Detailed Evidence Review** |
| **A2.1 Evidence base**   * This specification draws its evidence and rationale from a range of documents as listed below:   DH   * NHS Long Term Plan * NHS Cancer Plan * NHS Genomic Medicine Strategy <https://www.england.nhs.uk/publication/accelerating-genomic-medicine-in-the-nhs/>   NICE   * Lung Cancer: The diagnosis and treatment of Lung Cancer – NG122 * Quality Standard for Lung Cancer (2019) * Suspected cancer: recognition and referral – NG12 (2015) * Improving Supportive and Palliative Care for adults with cancer (2004) * Quality Standard for end of life care for adults (2011) * Care of dying adults in the last days of life – NG31 (2015)   Independent Cancer Taskforce Report  Radiotherapy for lung cancer - RCR consensus statements | The Royal College of Radiologists  Achieving world-class outcomes: a strategy for England 2015-2020  Quality Surveillance Team  Quality Indicators  Peer reviewed publications.  See references.  **A2.2 Why improving early diagnosis is a priority**   * There is good evidence to show that late diagnosis of lung cancer is a cause of poor outcomes in England and the UK(4, 5). In international comparisons, the UK lags other countries in lung cancer survival and this is mainly explained by differences in the early survival (0 to 1 year). In the latest comparison, Denmark has moved from the lowest position to middle for NSCLC and top for small cell lung cancer. This is attributed to the revised referral system(6, 7) that allows primary care to access secondary care rapidly, access to rapid diagnostic clinics and decision clinics. This is remarkably similar to the UK system but appears to work better in Denmark, probably because of better links between awareness and access to primary care alongside significant financial investment, buy-in from politicians through to clinicians and a clear cancer plan. It has also been shown that the Covid pandemic had no impact on lung cancer diagnosis and treatment in Denmark(8), in sharp contrast to the impact in the UK where both incidence and survival fell sharply(9). If it was ever in doubt, the importance of early presentation with symptoms to an effective access point was proven by the Covid pandemic which served as a natural experiment where early diagnosis through awareness and access was suppressed as part of the measures necessary to control the spread of infection. The result was a fall in incidence which meant that people were simply not diagnosed before they died. Furthermore, those who were diagnosed have a shorter survival(9).   Rates of diagnosis through the emergency route are also high in England at around 32% with only 13% of these people surviving 1 year (data from 2018)(10). There is also evidence that earlier diagnosis may be achieved through awareness campaigns: the Be Clear on Cancer campaign has resulted in a modest increase in earlier stage disease and an increase in resection rates. However, there is also evidence that people who are diagnosed late with lung cancer have- increasing contact with primary care in the weeks and months leading up to the diagnosis(11). The International Cancer Benchmarking Partnership found that, unlike patients from other countries, UK patients were concerned about wasting doctor’s time when they had red-flag symptoms. This will be mitigated by clear messaging and improved access to clinical assessment. There is also evidence that the use of the chest X-ray as a diagnostic tool in primary care could be improved with better targeting at those with high risk(11, 12). There is less scope to reduce delay in secondary care services but there is some evidence that even small changes in the time to diagnosis in secondary care can improve outcomes(13). The NOLCP has resulted in good performance against the 28-day faster diagnosis standard, but many elements can be improved. LCS has been recommended by the UKNSC and is underway in England as the TLHC.  **A.2.3 Why reducing variation is a priority**  Published evidence shows that there is wide variation in treatment rates and that larger centres achieve higher treatment rates and better surgical survival.(14, 15) However, the benefit of higher treatment rates is mostly confined to the patients whose first secondary care appointment is at a centre.(16) Such patients are 37% more likely to receive surgery for their lung cancer after correction for other factors influencing the likelihood of receiving surgery and there are similar findings for chemotherapy treatment rates. Only 30% of lung cancer patients are first referred to a centre, so the majority do not benefit from the better outcomes seen at larger centres. Other evidence has demonstrated variation in the pathways of care and functioning of the lung cancer MDT; centres have larger MDTs, more diagnostic services on site and more specialists in lung cancer diagnostics and treatment.(17-19) Faster diagnostic pathways were associated with, in a randomised controlled trial, an improvement in survival(13), and the presence of diagnostics on site (e.g. a PET scanner) has been shown to be associated with better surgical resection rates.(20) It is unrealistic for smaller hospitals to develop the same concentration of expertise and specialist equipment. Thus, a mechanism is needed to ensure that all patients have access to the expertise that should lead to the same approach seen at larger centres. Asking patients to travel long distances to centres for their first appointment is unlikely to be a successful strategy as lung cancer patients are elderly (median age 73 years) and probably reluctant to travel. Distance to travel has been confirmed as an independent factor in survival in the UK and Australia (21-23). One solution is to provide as much as the same expertise available at large centres locally from the initial appointment with the respiratory physician and throughout the pathway of care. Where travel is necessary for specialised treatment it has to be supported. Where these expert services are commissioned from will depend on local factors. The patient and carers will need personalised care and support throughout the pathway, especially when considering the option of travelling for treatment as this has been shown to lead to better joined up services.  **A2.4 Why living with cancer is a priority**   * Only 30% of people diagnosed with lung cancer survive 1 year and during this time they have distressing symptoms, especially towards the end of life. Treatment for advanced disease causes significant side effects. People are often elderly. There is evidence that early supportive / palliative care improves quality of life, reduces depression, and increases satisfaction with care. In some studies there has been an improvement in survival.(24, 25) For this care to be correctly targeted, there needs to be early and regular assessment of needs. The lung cancer nurse specialist (LCNS) is best placed to provide the essential holistic and supportive care, as well as an expert view of the individual’s position on the pathway from pre-diagnosis to end of treatment Macmillan 13 found that certain groups of cancer patients, including lung cancer patients, experience higher levels of distress, and those from poorer backgrounds and those with co- morbidities are also more likely to suffer psychological and emotional problems as a result of a cancer diagnosis. Both these patient groups have a higher incidence of lung cancer. Patients who receive support are more compliant with medical recommendations and more involved in the process of treatment15. Neglecting psychological problems exacerbates illness and increases health care costs. When the emotional needs of cancer patients remain unresolved, they are more likely to use community health services, visit their GP and spend more time in hospital13. The LCNS needs to be a constant presence for the patient to deliver this support. * It is not just cancer patients who suffer psychologically: 67% of carers experience anxiety and 42% experience depression 13. Studies have also shown that spouses are as distressed as cancer patients and that spousal and patient distress are correlated14.   The LCNS will have a close working relationship with specialist palliative care services that are often required to meet the needs of patients; early assessment by specialist palliative and supportive care is now available as part of the Enhanced Supportive Care Initiative. Patient experience is reported in the National Cancer Patient Survey. In this survey, patients with a Clinical Nurse Specialist reported much more favourably than those without on a range of items related to information, choice and care. NICE guidance NG122 and the NICE Quality Standard QS17 recommend, as a priority, that all patients should be seen by a LCNS at all key stages of the pathway and at the end of treatment. Recent research has demonstrated an association between increased treatment rates and being seen by a LCNS and that there is an association between higher salary banded LCNS and the frequency that patients are seen, suggesting that organisation of teams of LCNS may be important. The number of new patients seen annually per LCNS is very variable; median 90 (range 10 to 413).(26) |

|  |
| --- |
| * **Section A3: Guideline compliant service provision (see latest guidelines for updates)** |
| The following section is a summary of some of the current recommendations for care of patients with suspected or confirmed lung cancer. These are subject to regular updates and services need to keep abreast of these. NICE NG122 recommendations are in italics.  **A3.1 Diagnosis, staging and fitness assessment**  Services must ensure NICE guidance on diagnosis and staging is followed; use of the diagnostic standards of care (DSOC) in the NOLCP are recommended to ensure the correct diagnostic pathways are used consistently:   * + 1. People with suspected lung cancer should be offered a contrast-enhanced computed tomography (CT) scan of the neck, chest, and upper abdomen to include liver and adrenals. For those on the urgent cancer pathway, this should be offered prior to their first outpatient appointment.     2. People with lung cancer, following initial assessment and (CT) scan, are offered investigations that give the most information about diagnosis and staging with the least risk of harm (qs 4).     3. People with lung cancer have adequate tissue samples taken in a suitable form to provide a complete pathological diagnosis including tumour typing and sub-typing, and analysis of predictive biomarkers (to include PDL1 and genomic testing (qs 6).     4. Where diagnostic, staging and fitness tests are not available locally, there must be robust referral processes with the timely turnaround of tests (see radiotherapy for lung cancer RCR consensus statement)     5. RCR consensus is that PET-CT should be within 6 weeks (ideally 4 weeks) of the start of radical therapy.     6. The use of liquid biopsy in suspected advanced lung cancer should be developed.   **A3.2 Treatment with curative intent**  Services must ensure that people with lung cancer have the best chance of being cured of their cancer by following NICE guidance, updates, and single technology appraisals. The RCR Consensus statement gives detailed recommendations concerning radiotherapy alone or in combination.   * + 1. *Offer patients with NSCLC who are medically fit and suitable for treatment with curative intent, lobectomy (either open or thoracoscopic) as the treatment of first choice (NICE 2011). Offer more extensive surgery (bronchoangioplastic surgery, bilobectomy, pneumonectomy) only when needed to obtain clear margins.*     2. More advanced surgical techniques that achieve the best outcomes for patients should be available.     3. Optimisation for curative treatment should include prehabilitation and rehabilitation.     4. People with lung cancer are offered assessment for multimodality treatment by a multidisciplinary team comprising all specialist core members.     5. People who are eligible for neoadjuvant or adjuvant SACT in any context should be offered this in line with the latest technology appraisals, including those drugs only available through the Cancer Drugs Fund.     6. *People with lung cancer stage I–III and good performance status who are offered radiotherapy with curative intent have access to and receive treatments that optimise the dose to the tumour while minimising the risks of normal tissue damage, including stereotactic ablative radiotherapy (SABR) and image-guided radiotherapy (IGRT).*     7. *People with limited stage SCLC are offered potentially curative chemo-radiotherapy, with concurrent chemo-radiotherapy preferred for patients with good performance status*   **A3.3 Treatment with palliative intent**  Services must ensure that people with advanced lung cancer have the best chance of treatment that improves survival and overall quality of life, by following NICE guidance, updates, and single technology appraisals. The RCR Consensus statement gives detailed recommendations concerning radiotherapy alone or in combination.   * + 1. All patients with non-small cell lung cancer and eligible performance status should receive full molecular testing to guide treatment.     2. People with stage IIIB or IV non-small-cell lung cancer and eligible performance status are offered systemic therapy (first, maintenance, and second-line) in accordance with NICE guidance (including those therapies available through the Cancer Drugs Fund) that is tailored to the pathological sub-type of the tumour and individual predictive factors (qs 12). Systemic therapy must be administered in line with the recommendations of the National Chemotherapy Advisory Group and the NCEPOD (SACT).     3. People with stage III non-small-cell lung cancer and eligible performance status are offered the latest multimodality treatment.     4. People with small-cell lung cancer have treatment initiated within 2 weeks of the pathological diagnosis; pathways should reflect this with small cell lung cancer alerts from pathology.     5. People with lung cancer have access to all appropriate supportive and palliative interventions delivered by expert clinicians and teams. These include: * palliative radiotherapy (for airway obstruction, metastases, cough control and haemoptysis) * SABR, in line with approved commissioning- for example, metachronous relapse * endobronchial tumour treatment (brachytherapy, electrocautery, laser ablation, cryotherapy, stent insertion, photodynamic therapy) * pleural procedures (fluid drainage, pleurodesis, indwelling catheter) * supportive care (including a full holistic approach). * specialist pain control services. * denosumab for bone metastases   **A3.4 Living with cancer**  Services must ensure that people have the same access to care that improves aspects of living with cancer.   * + 1. People with known or suspected lung cancer have access to a named lung cancer nurse specialist who they can contact between scheduled hospital visits (qs 3).     2. People with lung cancer are offered a holistic needs assessment at each key stage of care that informs their care plan and the need for referral to other services (qs 3).     3. People with lung cancer are offered a specialist follow-up appointment within 6 weeks of completing initial treatment and regular specialist follow-up thereafter, which can include protocol-led clinical nurse specialist follow-up.     4. People with lung cancer are offered care integrated across primary and secondary care with liaison coordinated through specialist nursing teams.     5. Commission services that ensure that people with known or suspected lung cancer have information about their disease and options for treatment presented to them in a format they can understand, to enable them to make an informed choice, and in line with NICE guidance. Public health, mental health, palliative care services, cancer charities and patients and public representatives should all play a part in getting this right. Excellent communication between professionals and patients is particularly important and can avoid complaints and improve patient satisfaction.     6. The Independent Cancer Taskforce recommended that all consenting patients be given online access to all test results and communications involving secondary or tertiary providers by 2020. This has caused issues for patients who will need support in interpreting and coping with their results.     7. Commission services that ensure people with stage IV lung cancer, irrespective of other treatment options offered, are also routinely offered a specialist supportive / palliative care assessment at the time of diagnosis.     8. Rehabilitation and prehabilitation is an important aspect of supportive care. There should be appropriate assessment of patient’s rehabilitative needs across the pathway and the provider must ensure that high quality pre / rehabilitation is provided. This should involve an agreed recovery package and may include: * Pulmonary pre / rehabilitation delivered pre or post treatment to improve dyspnoea and fatigue. * Nutritional interventions for people at high risk of malnutrition * These commissioning priorities action the key interventions recommended in “Living with and beyond cancer: taking action to improve outcomes.” * [Living With and Beyond Cancer: Taking Action to Improve Outcomes - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/living-with-and-beyond-cancer-taking-action-to-improve-outcomes) * **Structured Holistic Needs Assessment and care planning.** * Commissioners need to engage with nursing services to deliver holistic needs assessments for all lung cancer patients at key points of the pathway, namely at diagnosis, during treatment and end of treatment. * **Treatment Summaries.** * Treatment summaries are to be completed at the end of each patient’s treatment to improve communication between primary and secondary care and shared with the patient. * [Treatment summary (macmillan.org.uk)](https://www.macmillan.org.uk/documents/aboutus/health_professionals/recoverypackage/treatmentsummary.pdf) * **Patient education and support events (Health and Wellbeing Clinics)** * Well-being events are important for patients to network with their local community and access information relevant at a local level. Members of the MDT can offer their expertise to support these events which are often provided by charities . It is important commissioners support such events in line with government and charity recommendations. * [MAC16500HWBEGuideWeb (macmillan.org.uk)](https://be.macmillan.org.uk/Downloads/ResourcesForHSCPs/MAC16500HWBEGuideWeb.pdf) * **Advice about, and access to, schemes that support people to undertake physical activity and healthy weight management.** * Physical activity and health promotion are important to improve outcomes in patients with lung cancer. Local commissioners should be aware of the challenges of delivering schemes for the lung cancer population. Poverty and symptoms either from the cancer itself or existing co morbidities contribute to poor uptake of organized physical activity. An example of a successful programme can be found at the following link below: * [CARE - Notts County (nottscountyfc.co.uk)](https://www.nottscountyfc.co.uk/communityexpired/our-programmes/health/care/)   **A3.5 End of life care**   * Services must provide end of life care in line with NICE guidance and in particular the markers of high-quality care set out in the NICE Quality Standard for end-of-life care for adults. * Engage in a discussion about end of life prior to the terminal stage of illness; include a discussion about Respect / resuscitation status * Document these discussions about end-of-life care.   Services should provide end of life care in line with the principles set out in the NHSE endorsed End of life guidance that can be found at: [www.endoflifecareambitions.org.uk](http://www.endoflifecareambitions.org.uk)  An integrated service should be provided that crosses primary and secondary care, coordinated through specialist nursing teams, and includes, where appropriate, use of the Hospice service.  **A3.6 Research and clinical trials**  All patients should be considered for, and have access to, clinical trials. This applies to all stages and tumour subtypes. Where trials are not available locally, potentially eligible patients should be able to participate in trials at other sites if they wish. Clinicians should be up to date with eligibility criteria.  **A3.7 Getting it right first time (GiRFT) summary recommendations**   * 1. All trusts should have an overall radical treatment rate of 85% or more in those patients with NSCLC stages I-II and of performance status 0-2.   2. All trusts should have an overall surgical resection rate for NSCLC of over 20%.   3. All trusts that treat lung cancer with radiotherapy should be able to deliver SABR in line with the clinical commissioning policy.   4. All trusts should deliver radiotherapy in line with the Royal College of Radiologists consensus statements.   5. Where a patient has early-stage disease but is declined for radical treatment or does not have access to the full range of radical treatment options, more effective mechanisms should exist for a second opinion.   6. Trusts should monitor rates of post-surgical adjuvant and neoadjuvant treatments and this data should be available for national benchmarking.   7. Trusts should record and monitor multimodality treatment in stage IIIA disease and offer radical intent treatment as standard in fit patients.   8. Radical intent treatment should commence by day 49 of the overall NOLCP pathway. Furthermore, for surgery, thermoablation or radiotherapy, treatment should commence by day 16 after the decision to treat in line with NOLCP.   9. All trusts should improve their treatment rates with SACT to achieve greater than 70% treatment for fit patients with advanced NSCLC, and greater than 70% chemotherapy rates in small cell lung cancer.   10. Ensure that all patients with lung cancer have access to enhanced supportive care and/or specialist palliative care. Inpatient specialist palliative care provision should be available seven days per week.   11. Produce and implement protocols for follow-up pathways following radical therapies.   12. Clinical trial recruitment should be considered a focus for prioritisation, with MDTs collaborating to offer a wider regional portfolio. |

**A3.8 Education and communication**

There should be locally organised sessions to link primary and secondary care to provide updates about lung cancer and share the latest thinking on how best to jointly manage patients. These should happen at least every two years. Patient facing material should be regularly revised to give accurate information to patients.

1. Tod AM, Redman J, McDonnell A, Borthwick D, White J. Lung cancer treatment rates and the role of the lung cancer nurse specialist: a qualitative study. BMJ Open. 2015;5(12):e008587.

2. Stewart I, Khakwani A, Hubbard RB, Beckett P, Borthwick D, Tod A, et al. Are working practices of lung cancer nurse specialists associated with variation in peoples' receipt of anticancer therapy? Lung Cancer. 2018;123:160-5.

3. Stewart I, Leary A, Khakwani A, Borthwick D, Tod A, Hubbard R, et al. Do working practices of cancer nurse specialists improve clinical outcomes? Retrospective cohort analysis from the English National Lung Cancer Audit. Int J Nurs Stud. 2021;118:103718.

4. Walters S, Maringe C, Coleman MP, Peake MD, Butler J, Young N, et al. Lung cancer survival and stage at diagnosis in Australia, Canada, Denmark, Norway, Sweden and the UK: a population-based study, 2004-2007. Thorax. 2013;68(6):551-64.

5. Coleman MP, Forman D, Bryant H, Butler J, Rachet B, Maringe C, et al. Cancer survival in Australia, Canada, Denmark, Norway, Sweden, and the UK, 1995-2007 (the International Cancer Benchmarking Partnership): an analysis of population-based cancer registry data. Lancet. 2011;377(9760):127-38.

6. Probst HB, Hussain ZB, Andersen O. Cancer patient pathways in Denmark as a joint effort between bureaucrats, health professionals and politicians--a national Danish project. Health Policy. 2012;105(1):65-70.

7. Vedsted P, Olesen F. A differentiated approach to referrals from general practice to support early cancer diagnosis - the Danish three-legged strategy. Br J Cancer. 2015;112 Suppl 1:S65-9.

8. Olesen TB, Rasmussen TR, Jakobsen E, Engberg H, Hilberg O, Moller H, et al. Diagnosis and treatment of lung cancer in Denmark during the COVID-19 pandemic. Cancer Epidemiol. 2023;85:102373.

9. Morgan H GS, Navani N, Baldwin D, Hubbard R, O’Dowd E. The Impact of the SARS-CoV-2 Pandemic on Lung Cancer Survival in England: An Analysis of the Rapid Cancer Registration Dataset. Thorax. 2023.

10. NHS Digital. Routes to Cancer Diagnosis 2022 [Available from: <https://digital.nhs.uk/data-and-information/publications/statistical/routes-to-diagnosis/2018>.

11. O'Dowd EL, McKeever TM, Baldwin DR, Anwar S, Powell HA, Gibson JE, et al. What characteristics of primary care and patients are associated with early death in patients with lung cancer in the UK? Thorax. 2015;70(2):161-8.

12. Bradley SH, Kennedy MPT, Neal RD. Recognising Lung Cancer in Primary Care. Adv Ther. 2019;36(1):19-30.

13. Navani N, Nankivell M, Lawrence DR, Lock S, Makker H, Baldwin DR, et al. Lung cancer diagnosis and staging with endobronchial ultrasound-guided transbronchial needle aspiration compared with conventional approaches: an open-label, pragmatic, randomised controlled trial. Lancet Respir Med. 2015;3(4):282-9.

14. Rich AL, Tata LJ, Free CM, Stanley RA, Peake MD, Baldwin DR, et al. Inequalities in outcomes for non-small cell lung cancer: the influence of clinical characteristics and features of the local lung cancer service. Thorax. 2011;66(12):1078-84.

15. Rich AL, Tata LJ, Stanley RA, Free CM, Peake MD, Baldwin DR, et al. Lung cancer in England: information from the National Lung Cancer Audit (LUCADA). Lung Cancer. 2011;72(1):16-22.

16. Khakwani A, Rich AL, Powell HA, Tata LJ, Stanley RA, Baldwin DR, et al. The impact of the 'hub and spoke' model of care for lung cancer and equitable access to surgery. Thorax. 2015;70(2):146-51.

17. Beckett P, Edwards J, Fennell D, Hubbard R, Woolhouse I, Peake MD. Demographics, management and survival of patients with malignant pleural mesothelioma in the National Lung Cancer Audit in England and Wales. Lung Cancer. 2015;88(3):344-8.

18. Beckett P, Woolhouse I, Stanley R, Peake MD. Exploring variations in lung cancer care across the UK--the 'story so far' for the National Lung Cancer Audit. Clin Med. 2012;12(1):14-8.

19. Aveling EL, Martin G, Jimenez Garcia S, Martin L, Herbert G, Armstrong N, et al. Reciprocal peer review for quality improvement: an ethnographic case study of the Improving Lung Cancer Outcomes Project. BMJ Qual Saf. 2012;21(12):1034-41.

20. Woolhouse ISM, C. Greenaway, K. Beckett, P. Peake, M.D., editor Results From The First National Lung Cancer Organisational Audit. Thorax; 2015; London.

21. Tracey E, McCaughan B, Badgery-Parker T, Young J, Armstrong B. Survival of Australian lung cancer patients and the impact of distance from and attendance at a thoracic specialist centre: a data linkage study. Thorax. 2015;70(2):152-60.

22. Logan CD, Ellis RJ, Feinglass J, Halverson AL, Avella D, Lung K, et al. Association of travel distance, surgical volume, and receipt of adjuvant chemotherapy with survival among patients with resectable lung cancer. JTCVS Open. 2023;13:357-78.

23. Tracey E, McCaughan B, Badgery-Parker T, Young J, Armstrong B. Distance from accessible specialist care and other determinants of advanced or unknown stage at diagnosis of people with non-small cell lung cancer: A data linkage study. Lung Cancer. 2015;90(1):15-21.

24. Temel JS, Greer JA, Muzikansky A, Gallagher ER, Admane S, Jackson VA, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med. 2010;363(8):733-42.

25. Ferrell BR, Temel JS, Temin S, Alesi ER, Balboni TA, Basch EM, et al. Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update. J Clin Oncol. 2017;35(1):96-112.

26. Cusworth K, O'Dowd E, Hubbard R, Beckett P, Peake MD, Woolhouse I. Variation in lung cancer resources and workload: results from the first national lung cancer organisational audit. Thorax. 2015;70(10):1001-3.