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

**Summary of Essential Recommendations for Effective Services**

**(see full guidance and appendix for details)**

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| **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** |

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| **SE1.0 Key priorities for commissioning services for people with suspected and confirmed lung cancer** |
| **Early diagnosis, reducing variation and living with lung cancer.**  SE1.1Early diagnosis requirements.   1. **Public awareness** 2. **Recognition and referral** 3. **Lung Cancer Screening (LCS)**   SE1.2 Actions to reduce variation.   1. **Improve access to specialist care**   See recommendations for the minimum amount of specialist time needed at all sites   1. **Diagnosis and staging**   See recommendations for delivery of the National Optimal Lung Cancer Pathway (NOLCP)   1. **Treatment**   See recommendations for delivery of all treatments.   1. **Equality considerations**   Ensure the recommendations for commissioning services are implemented to address health inequalities.  SE1.3 Living with lung cancer   1. **See recommendations for supporting patients throughout their survivorship** |
| **SE2.0 Essential service specification for commissioning** | |
| SE2.1 Public awareness  The service must be supported by local, coordinated campaigns that increase public awareness of the symptoms and signs of lung cancer (LC), and the benefits of making the diagnosis.  SE2.2 Recognition and referral  Recommended methods include:  Primary care based assessment of risk of LC  The latest decision support tools  Rapid referral for imaging and prompt action (within 2 weeks)  Direct referral for CT from primary care supported by an agreed protocol.  Cancer concern hotlines (with in-service evaluation).  Self-referral for chest X-ray (with in-service evaluation).  Appropriate safety netting for those with persistent symptoms.  SE2.3 Access to specialist care  Providing adequate specialist time supports recommendations that reduce variation in access to the best and most cost-effective care thereby being the best use of resources. Clinicians or patients may need to travel to different hospitals to ensure equity of access to specialist care. Where it is necessary for patients to travel due to the location of specialised equipment and services there should be standardised national mechanisms for easy and equitable reimbursement for costs incurred by patients and carers.  **Minimum clinical time commitments**  The time commitments below are mostly given in relation to **the number of new patients diagnosed with LC each year per secondary care provider**. Where a service (tertiary) provides services to more than one provider (e.g. thoracic surgery) the number of new patients **is the sum of the number of diagnoses in the providers served** (or the proportion served if there is more than one tertiary service). Please see full commissioning guidance for detail on the derivation.  For each secondary care provider, there should be access to:   * 10 direct clinical care (DCC) respiratory physician PAs per 200 new LC patients per year and 1 DCC PA per 30 participants in the LCS programme referred to secondary care (work-up or discussion). * A first appointment at the local hospital with a respiratory physician * 10 DCC thoracic radiologist PAs per 200 new LC patients, with continuous cover for interventional procedures and 1 PA per 30 participants referred to secondary care from the LCS programme. * 10 DCC medical oncologist time dedicated to LC per 200 new lung cancer patients. * 10 DCC clinical oncologist time dedicated to LC per 200 new lung cancer patients. * A minority of MDTs have minimal or no medical oncology input so that the majority of systemic therapy is provided by clinical oncologists. DCC PAs should be a total of 20 per 200 new LC patients. * One WTE LCNS per 40 new LC diagnoses per year including one band 7 or above per 80 new diagnoses. * 1.5 WTE palliative care nurse specialists per 200 new LC diagnoses. * 2 DCC PAs of specialist supportive / palliative care consultant time per 200 new LC diagnoses * 10 DCC of specialist pulmonary pathologist time per 300 new LC patients. * Fast track, pre-clinic CT pathway * Separate diagnostic planning process or MDT from treatment LC surgery of 5 PAs per 200 new LC patients assuming a resection rate of 20%. DCCs should be adjusted according to resection rate. * Specialist radiological imaging (PET-CT etc.) * Bronchoscopy, endobronchial ultrasound, thoracoscopy, radiological biopsy * Thoracic surgical diagnosis and staging * Lung function and exercise testing * Specialist diagnostic pathology * Advanced early diagnostic facilities at larger centres to facilitate diagnosis in the LCS programme * For tertiary services increased provision is required according to the activity provided (section 4.3.11 of full guidance)   SE2.4 Diagnosis and staging  Follow the National Optimal Lung Cancer Pathway (NOLCP)  SE2.5 Treatment and equity  Maximise the number of patients that can be offered treatment through implementation of the NOLCP and provision of expert time as in 2.2 above; ensure this is offered equitably according the geography and sociodemographic.  SE2.6 Living with cancer.  Ensure all patients have access to supportive care appropriate to their needs to maximise quality of life and benefit from treatment. | |