SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	170016/S
Service	Thoracic Surgery - Adults
Commissioner Lead	*For local completion*
Provider Lead	*For local completion*

1. Scope

1.1 **Prescribed Specialised Service**
This service specification covers the provision of Adult thoracic surgery services.

1.2 **Description**
Adult thoracic surgery services include all services provided by Adult Thoracic Surgery Centres, including outreach when delivered as part of a provider network.

1.3 **How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners**
NHS England commissions all adult thoracic surgery service from Adult Thoracic Surgery Centres, including services delivered on an outreach basis as part of a provider network. Clinical Commissioning Groups (CCGs) do not commission any element of this service.

2. Care Pathway and Clinical Dependencies

2.1 Care Pathway
The principle disease requiring management by thoracic surgery is primary lung cancer. The remaining conditions include other types of thoracic malignancies, pneumothorax, various forms of thoracic sepsis and a large group of miscellaneous conditions which fall outside the remit of other surgical specialties.

Given the particular requirements of care needed for patients undergoing thoracic

operations and also the relative infrequency of thoracic surgery as compared to those provided by other surgical specialties (e.g. orthopaedics, general surgery etc.) for over 40 years services have been concentrated in specialist hospitals serving large regions.

Please note that access to treatment will be guided by any applicable NHS England national clinical commissioning policies.

2.1.1 Organisation of services

- Thoracic surgery should be identified as a separate service line within the hospital's directorate structure.
- 24/7 emergency cover should be provided by general thoracic surgical consultants with or without mixed-practice cardiothoracic surgical colleagues. This should be appropriate to the service requirements. The surgeons on the rota should be able to deal with the full range of thoracic surgical emergencies. Cross cover of rotas from consultants with a purely cardiac practice or from consultants from other specialties is unacceptable.
- 24/7 cover of thoracic surgical inpatients should be provided from surgical trainees, speciality doctors and appropriately trained advanced care practitioners.
- Consultant thoracic surgeons are core members of lung cancer multi-disciplinary teams (MDT's). These meetings, which occur on a weekly basis, are based in all hospitals in England. There are over 130 such meetings every week requiring attendance by thoracic surgeons. Thoracic surgical Units are therefore required to ensure that the job plans of their surgeons include sufficient time for travel to and attendance at the lung cancer MDT's in their region. This should preferably be in person although teleconference linkage with the meetings from the surgeons' base hospital is an appropriate alternative.
- New peer-review measures require a quorum of core member attendance at MDT's for 95% of the time. It is therefore necessary that services are arranged to ensure cover for individual consultant surgeons' absences from the MDT's due to annual, professional and study leave. This cover should be provided by named consultant colleagues and/or competent specialty doctors.
- For those patients with early stage disease who are turned down for surgery, Thoracic surgical Units should have protocols to facilitate the provision of a second opinion as to the patient's suitability for surgery.
- Patients are seen for opinions as to their suitability for thoracic surgery and pre-operative assessment in dedicated thoracic 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.
- For those hospitals without on-site thoracic surgery it is essential that the populations they serve are not disadvantaged in any way. These hospitals should have close links with nominated surgeons working in the regional centre, such that thoracic surgical expertise can be accessed throughout the working week. It is essential that these hospitals ensure that all relevant patient information especially documentation and imaging via

PACS (e.g. CT and PET-CT scans) is readily available to the regional centre.

2.1.2 Consultant surgical staffing

There is good evidence that the appointment of surgeons with a full-time thoracic job plan in preference to mixed-practice cardiothoracic surgeons is associated with an overall increase in lung cancer survival in England. (Lau et al, 2013, Luchtenborg et al, 2013)

Although thoracic surgery is becoming more specialised, surgeons with mixed-practice cardiothoracic surgery currently provide a substantial proportion of thoracic surgeryin England. A survey of (SCTS 2015) consultant staffing of thoracic surgical services in England showed that there were 80 full-time thoracic surgeons and 32 mixed practice surgeons. Because of the limitations of training time, the increasing breadth of knowledge and therapies within the specialty of cardiothoracic surgery, and the need for surgeons to contribute to MDT meetings, it is clear that in the long term mixed-practice surgeons will be replaced by consultants with job plans consisting entirely of either thoracic or cardiac surgery.

The proportion of thoracic surgical practice within the overall workload of the 32 mixed-practice surgeons varies between a very small amount and over 50% of their practice. In contrast there are currently over 200 consultants with a full-time cardiac practice in England. Therefore the contribution of the mixed-practice surgeons to the overall cardiac surgery workload in England is relatively small. It is likely that those mixed-practice surgeons with a 50:50 division of their work are the ones who will move to full-time thoracic surgery, whereas those with a small thoracic practice will become full-time cardiac surgeons. Therefore the improvements in services for thoracic surgical patients envisaged by this service specification will have a negligible impact on cardiac surgical services in England

Based on likely retirements over the next 5 years, the need to produce sufficient numbers of thoracic trainees to become available to fill the consultant posts for the service and the time needed for Units to make the appropriate adaptations to their staffing arrangements, based on the requirements of the service specification already alluded to, it will not be necessary for Units to employ surgeons who have a mixed cardiothoracic practice beyond the year 2020 at the latest.

If not already present, plans should be made within each Unit to have a minimum of 3 full-time general thoracic surgeons leading thoracic surgical services. There should be no new appointments of surgeons with mixed-practice cardiothoracic surgical job plans.

In the meantime, to maintain an appropriate standard of thoracic surgery, those Units which continue to employ mixed-practice cardiothoracic surgeons should ensure the following areas of clinical activity are present within their job plans:

- Dedicated thoracic theatre sessions with at least one whole-day list per week. Anything less than this would mean that it would be impossible for surgeons to provide sufficient level of activity for their employing Trusts to be assured of their

competencies.
- Weekly lung cancer MDT
- Inclusion in the emergency on-call rota for thoracic surgery
- Appraisals should include specific reference to thoracic outcomes and activities.

The practice of arranging for a mixed cardiothoracic list where thoracic procedures are listed after a cardiac operation should no longer be a part of modern cardiac or thoracic surgery.

2.1.3 Trauma services

Major trauma centres require input from specialised cardiac and thoracic surgeons. Although the number of patients actually affected by chest trauma requiring this service is small, on such occasions the input of an appropriately trained specialist surgeon can be life-saving. The current standard is that a specialist cardiothoracic surgeon is available within 30 minutes to assist in the care of those patients with life-threatening chest trauma. There is significant variation throughout the country as to how this is organised for the trauma centre by the regional cardiac and thoracic Units. In some cases all trauma is looked after by one side of the specialty, leading to concern over inferior care for patients – for example a patient with cardiac trauma is cared for by a thoracic surgeon and vice-versa.

With increasing specialization and separation between cardiac and thoracic surgical services, there will be two emergency rotas for surgeons to be available to help with trauma, whereas in most cases there is currently only one. There will therefore be an improvement in the care of patients with major chest trauma as a result of the changes specified in this document.

2.1.4 Commissioning for highly specialised Thoracic Surgery

The following areas of medicine which rarely require surgical treatment have been identified as of being of sufficient rarity for it to be impractical for every Thoracic Surgical service to provide for them:

- Complex tracheal diseases especially those being considered for resection
- Radical surgery for mesothelioma
- Thoracic surgical diseases in children.

Services for patients in these groups should be configured based on the number requiring operative thoracic surgical treatment, although the exact numbers of procedures per unit for optimum care of patients will require further debate. Given the population of England and the rarity of some of the conditions it is conceivable that in some instances only one centre is commissioned in England to carry out the very rare operations.

Please note that access to treatment will be guided by any applicable NHS England national clinical commissioning policies.

2.1.5 Population covered, and operative workload of Thoracic Surgical Units

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. As the majority of the patients in the service are managed within the 62 and 31-day cancer targets, the intervals to be seen in thoracic surgical clinics are short, which also benefits those thoracic surgical patients with non-malignant conditions. The peripatetic nature of thoracic surgeons' work in attending peripheral clinics further facilitates access.

Evidence (Luchtenborg et al, 2013) regarding the operative workload of Thoracic Units and outcomes after primary lung cancer surgery show that there is a positive correlation between high volume Units and patient survival. Those Units carrying out more than 150 resections per year (especially when compared to those carrying out less than 70 resections) have the best short and long term survivals for their patients, despite operating on higher-risk patients. Thus the aspiration for the service in England should be that all Units should carry out at least 150 lung cancer resections per year, this should be achieved by 2018/19. No Units should provide a lung cancer surgical service where less than 70 patients are treated per year.

Eighteen of the current 29 Units England carried out at least 150 annual resections (SCTS 2014). Of the remaining 11 Units, 2 are already in the process of moving their thoracic surgical services to neighboring Units. The other 9 Units carried out between 65 and 126 resections in 2013-14. It is likely that the numbers will continue to increase in all Units over the next few years given the increasing proportion of lung cancer patients being treated with surgery, especially with the increasing numbers of general thoracic surgeons in post. If this doesn't occur such that not all Units are able to offer a high-volume lung cancer service, then some current providers will no longer be able to provide an adequate long-term Thoracic Surgical service for lung cancer patients. It is anticipated that the target of over 150 resections for primary lung cancer per Unit per year will be applicable for commissioning of services for the year 2018-19.

The specifications outlined in this document mean that in order to satisfy the requirements for a Unit to provide 24/7 emergency cover as well as other duties by at least 3 competent thoracic surgeons, the minimum population served by thoracic surgical units would need to be in the order of 1.5 million. This figure will vary depending on the incidence of thoracic disease within the population served, especially the incidence of lung cancer. Although there is good evidence that the UK has an under-provision of thoracic surgery, spreading the expertise of thoracic surgery too thinly or diluting it within the job-plans of consultants such that they spend the majority of their time providing a cardiac surgical service will not help to remedy this under-provision. On the contrary there is good evidence that the appointment of surgeons with a full-time thoracic job plan at the expense of mixed-practice cardiothoracic surgeons leads to an overall increase in activity and survival. This is clearly the way forward for the service in the medium to long-term.

2.1.6 Any acceptance and exclusion criteria and thresholds

Thoracic Surgery is an inclusive service for all patients requiring or being assessed for operative treatment of all conditions affecting the thorax, excluding the following:-

- Diseases of the heart and great vessels which are the remit of Cardiac Surgery
- Oesophagogastric cancer.

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

2.2 Interdependence with other Services

The following services and facilities are essential for the safe and effective provision of thoracic surgical services:

- Respiratory Medicine is the prime referring speciality for most conditions requiring thoracic surgery. Respiratory physicians are core members of lung cancer and emphysema MDTs. Management of empyema, pneumothorax and pleural effusion may be conducted jointly. Respiratory Medicine colleagues are usually responsible for the supervision of lung function testing and pulmonary rehabilitation. It therefore essential that Respiratory Medical services are closely allied to those for Thoracic Surgery. In most cases the two services will be co-located on the same site; if this is not the case then plans should be made by providers to ensure that this occurs for the commissioning of services in 2017.
- Out-patient clinic space, including facilities for pre-op assessment and pre-admission.
- Specialised thoracic surgical ward.
- Specialised thoracic operating theatres and recovery area.
- Access to interventional bronchoscopy.
- Immediate access to thoracic surgical high-dependency (level 2) and/or intensive care (level 3) units for selected patients.
- Support from the full range of specialist thoracic pathology services. This should be easily accessible especially for frozen section analysis of intra-operative specimens, the results of which should be communicated with the operating surgeon within 1 hour of the sample being taken.
- Support from all other hospital services including interventional radiology.

Staffing of Thoracic Units

- Consultant-led care by general thoracic surgeons, with or without surgeons with a mixed cardiothoracic practice (see section 2.1.1), supported by surgical trainees and/or specialty doctors and advanced care practitioners.
- Consultant anaesthetists with specialist thoracic expertise.
- Theatre staff with thoracic expertise.
  - Specialist ward and HDU nurses with thoracic expertise.
  - Specialised thoracic physiotherapy, including a service out-of-hours and at weekends.
  - Specialist support in areas such as pre and post-operative assessment, post-

operative pain control, and palliative care.

- Lung cancer nurse specialist support in thoracic surgical clinics andwards.
- Thoracic nurse specialist support in all areas.
- Designated administrative staff to ensure all clinical staff are supported in the timely delivery and monitoring of an effective service.

3. Population Covered and Population Needs

3.1 Population Covered By This Specification

Thoracic Surgery comprises the pre, peri and post-operative care of all patients (of all ages) requiring or being assessed for operative treatment of all conditions affecting the thorax, excluding those affecting the heart and great vessels (which are the remit of cardiac surgery).

Thoracic surgery in children is a much rarer requirement than in adults and will be the subject of separate commissioning.

3.2 Population Needs

Because of the frequency of primary lung cancer in the UK population (over 40,000 new cases every year) the majority of patients being managed by thoracic surgeons are affected by this disease. As surgery is the main therapeutic modality providing a chance of cure for lung cancer patients it is crucial that as many patients as possible have access to surgery. The latest report from the UK National Lung Cancer Audit shows that there are significant inequalities throughout the country in terms of access to surgery and subsequent surgical treatment, with a two-fold variation between cancer networks with the lowest and highest surgical resection rate. In addition the rate of surgical resection for patients in the UK with primary lung cancer is significantly lower than in other developed countries. Calculations incorporating incidence of the disease, the age and co-morbidity of the patients and the early mortality associated with surgery estimate that if all areas of the UK had the same access to surgery as the cancer network with the highest resection rate, over 5,000 deaths from lung cancer would be prevented every 3 years.

Information from the 2010-2011 Society for Cardiothoracic Surgery (SCTS) Thoracic Surgical Register shows that only 29 hospitals throughout England provided thoracic surgery. 22,548 operations were carried out in total, of which 15,302 were classified as major procedures. The number of total/major operations performed within each of the 29 units ranged from 237/183 to 1,974/1,197 procedures per year.

3.3 Expected Significant Future Demographic Changes

Not applicable.

3.4 Evidence Base

- NICE 2011 – The diagnosis and treatment of lung cancer (http://www.nice.org.uk/nicemedia/live/13465/54199/54199.pdf)
- British Thoracic Society – Guidelines on the radical management of patients with lung cancer Thorax 2010, 65(Supp III):iii1-iii27

- Society for Cardiothoracic Surgery, GB and Ireland, Second National Thoracic Surgery Activity & Outcomes report 2011
- Published by Dendrite Clinical Systems Ltd. Henley-on-Thames
- ISBN 978-0-9568154-1-5.
- National Lung Cancer Audit Report 2013
- (http://www.hscic.gov.uk/catalogue/PUB12719/clin-audi-supp-prog-lung-nlca-2013-rep.pdf)
- Manual for Cancer services Acute Oncology Measures 2011

4. Outcomes and Applicable Quality Standards

4.1 Quality Statement – Aim of Service

As described in section 2.1.

NHS Outcomes Framework Domains

Domain 1	**Preventing people from dying prematurely**	**x**
Domain 2	**Enhancing quality of life for people with long-term conditions**	**x**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**x**
Domain 4	**Ensuring people have a positive experience of care**	**x**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**x**

4.2 Indicators Include:

No.	Indicator	Data source	Domain(s)	CQC Key Question
Clinical Outcomes				
1	% of patients discussed at an MDT.	COSD	1, 2, 3, 4, 5	Safe, Effective, Well Led
2	% of eligible patients offered the chance to be treated in a clinical trial.	COSD	1, 2, 3	Effective, Responsive, Well Led
3	Number of surgical procedures.	SCTS	1, 5	Effective

4	Number of patients cancelled.	SCTS	4, 5	Responsive, Well Led
5	One year relative survival.	SCTS	1	Safe, Effective
6	Five year relative survival.	SCTS	1	Safe, Effective
7	30 day mortality after surgery	SCTS	1	Safe, Effective
8	90 day mortality after surgery	SCTS	1	Safe, Effective
9	Resection rate for histologically confirmed Stage 1 and 2 non-small cell lung cancers	SCTS	1	Safe, Effective
10	Systematic Nodal Dissection for lung cancer resections. % of patients in whom three separate mediastinal nodal stations are obtained.	SCTS	1	Safe, Effective
11	% patients with air leak after lung resection for primary cancer.	SCTS	1	Safe, Effective
12	% returned to theatre. (to exclude endoscopy and drain insertion).	SCTS	1	Safe, Effective
13	% of patients being readmitted to ITU.	SCTS	1	Safe, Effective
14	% of patients requiring ventilation.	SCTS	1	Safe, Effective
15	Average length of stay.	COSD	3, 4, 5	Safe, Effective
Patient Outcomes				
16	% patients seen by a CNS	CHI	1, 2, 3, 4, 5	Effective, Caring, Responsive, Well Led
17	% patients receiving adequate information	CPES	1, 2, 3, 4, 5	Caring, Responsive
18	Number of viable survey questions and % of those questions scoring green	CPES	4	Caring, Responsive
Structure & Process				
19	There is a named lead clinician with responsibility for thoracic surgery.	Self declaration	1, 2, 3, 4, 5	Safe, Effective, Well Led
20	For thoracic surgical units there are at least	Self declaration	1, 2, 3, 4, 5	Safe, Effective, Well

	three named thoracic surgeons on the lung MDT.			Led
21	The MDT should have treatment planning meetings scheduled every week unless the meeting falls on a public holiday. The attendance at each individual scheduled treatment planning meeting should constitute a quorum, for 95% or more, of the meetings.	Self declaration	1, 2, 3, 4, 5	Safe, Effective, Well Led
22	There is 24/7 emergency cover provided by general thoracic surgical consultants with or without mixed-practice cardiothoracic surgical colleagues.	Self declaration	1, 5	Safe, Effective
23	The thoracic surgical unit meets the population requirements as set out in the national service specification for thoracic surgery.	Self declaration	1, 3, 4, 5	Safe, Effective
24	The thoracic surgical unit carries out at least 70 lung cancer resections per year, rising to 150 by 2018/19.	Self declaration	1, 2, 3, 4, 5	Effective
25	There is access to services and facilities as set out in the national service specification; including ward, theatre with dedicated lists, access to ITU/HDU, interventional bronchoscopy and pathological support.	Self declaration	5	Safe, Effective
26	There are clinical guidelines in place which, where available, reflect national guidelines.	Self declaration	1, 2, 3, 4, 5	Safe, Effective
27	There are agreed patient pathways in place.	Self declaration	1, 2, 3, 4	Safe, Effective
28	The thoracic surgical unit submits data to the LUCADA, COSD and SCTS dataset.	Self declaration	1, 2, 3, 4, 5	Well Led
29	Participation in national audit.	Self declaration	1, 2, 3, 4, 5	Well Led

The SCTS Thoracic Surgical Register is a long-term initiative to which all Units have contributed for many years. The SCTS Thoracic Surgical Database has become available from April 2013.

The National Lung Cancer Audit (usually known as LUCADA) is a separate project which looks at the management of all patients developing lung cancer throughout the UK. Data are collected via lung cancer MDT's. Thoracic Surgical Units must ensure that the relevant information is available to staff at the MDT's in their referring hospitals to ensure comprehensive reports on outcomes for patients.

As well as the aforementioned SCTS Thoracic Surgical Database outcome measure, the following parameters should also be used for the monitoring of thoracic surgical units:

- For hospital inpatients, time from decision-to-transfer to admission to the thoracic surgical Unit of non-elective referrals – Domains 1, 2, 3, 4, 5
- Time from referral to first appointment in the thoracic surgical out-patient clinic – Domains 1, 2, 3, 4, 5
- Overall cancellation rate for thoracic surgery – Domains 1, 2, 3, 4, 5

Detailed definitions of indicators, setting out how they will be measured, is included in schedule 6.

4.3 Commissioned providers are required to participate in annual quality assurance and collect and submit data to support the assessment of compliance with the service specification as set out in Schedule 4A-C

4.4 Applicable CQUIN goals are set out in Schedule 4D

5. Applicable Service Standards

5.1 Applicable Obligatory National Standards

Department of Health

- Improving Outcomes; a Strategy for Cancer – Department of Health (2011) with updates to 2014.
- Cancer Commissioning Guidance - Department of Health (2011)
- Five year forward view - Department of Health (2014)
- Report of the Independent Cancer Taskforce - 'Achieving World-Class Cancer Outcomes: A Strategy for the NHS 2015-2020'

NICE

- Improving Supportive and Palliative Care for adults with cancer - NICE (2004)
- Improving Outcomes in Lung Cancer – NICE (1998)
- Referral guidelines for suspected cancer - NICE Clinical Guideline 27 (2005)
- Quality Standard for Lung Cancer – NICE (2012)
- Quality Standard for end of life care for adults – NICE (2011)
- Lung Cancer: The diagnosis and treatment of Lung Cancer – CG121 (2011)

Cancer Peer Review

- Manual for Cancer Services: Lung Measures, Version 1.1 April 2013 – National Cancer Peer Review Programme, NHS England.

5.2 Other Applicable National Standards to be met by Commissioned Providers

- There must be access to the centrally provided diagnostic pathology service including molecular diagnostics.
- The pathology services should operate as per Royal College of Pathologists' guidelines and standards.
- Laboratories should comply with Clinical Pathology Accreditation (UK) Ltd (CPA) and participate in appropriate NEQAS modules.
- Where pathology is available, pathologists should complete the Royal College of Pathologists' minimum dataset for lung cancer for discussion at the lung cancer MDT.
- All non-squamous cancers should be sent for mutation testing where targeted treatment of the mutations would be offered. Mutation testing should not be done for patients who are too unfit for treatment or in those offered surgical resection, as adjuvant treatment with biological agents is not currently recommended.

5.3 Other Applicable Local Standards

Not applicable.

6. Designated Providers (if applicable)

Not applicable.

7. Abbreviation and Acronyms Explained

The following abbreviations and acronyms have been used in this document:

CCG: Clinical Commissioing Group
CHI: Clinical Headline Indicators
COSD: Cancer Outcomes and Services Dataset
CPES: Cancer Patient Experience Survey
MDT Multi-disciplinary team
NEQAS: National External Quality Assessment Service
NICE National Institute for Health and Clinical Excellence
SCTS: Society for Cardiothoracic Surgeons

Appendix One

All Providers delivering services outlined within this document are required to participate in national audits and data collection, where this exists.
Quality and Performance Standards

Quality standards specific to the service using the following template:

	Performance Indicator	*Threshold*	*Method of Measurement*	*Consequence of breach*
Quality				
Domains 1 & 5	% of cases discussed at multidisciplinary team	100%	Reported within national audit reports	As per standard NHS Contract, General Conditions Clause 9 (GC9)
Domains 1, 2, 3, 4 & 5	Percentage attendance by individual core members or their agreed cover at multidisciplinary team	95%	National Cancer Peer Review	GC9
Domains *1, 2, 3, 4 & 5*	Compliance with specific measures for tumour site as set out in IOG documentation, NICE Quality Standards and this specification.	100%	National Cancer Peer Review	GC9
Domains *1, 2, 3, 4 & 5*	62 day wait - % treated in 62 days from GP referral, consultant referral and referral from screening programme	85%	Reported on cancer waits database	GC9
	14 day suspected cancer referral standard performance (A20)	94%	As above	GC9
	31 day first treatment standard performance (A15)	96%	As above	GC9
	31 day subsequent treatment (Surgery) standard performance (A16)	94%	As above	GC9
	31 day subsequent treatment (Drugs) standard performance (A16)	98%	As above	GC9
	31 day subsequent treatment (Radiotherapy) standard performance (A17)	94%	As above	GC9

	31 day subsequent treatment (Other Treatments) standard performance	TBC	As above	GC9
	31 day subsequent treatment (Palliative) standard performance	TBC	As above	GC9
	62 day standard from 14 day referral performance (A18)	TBC	As above	GC9
	62 day standard from 14 day referral performance (A18)	100%	Trust reported	GC9
	62 day standard from consultant upgrade performance (A19)	100%	National Cancer Peer Review	GC9
Domains 2 & 5	Ensuring all patients receive patient information	100%	National Cancer Peer Review	GC9
Domains 1, 2, 3, 4 & 5	Ensuring all patients have a named key worker who is a lung cancer trained CNS	>80%	National Cancer Peer Review	GC9
Domains 1, 2, 3, 4 & 5				

Activity Performance Indicators		Threshold	Method of Measurement	Consequence of breach
Domains 1, 2, 3, 4 & 5	Annual review of Audits conducted	Yes	Trust Reported	GC9
	Participation in National Audits, including LUCADA	100%	Trust Reported	GC9
Domains 1, 2, 3, 4 & 5	Threshold for number of procedures			
	Therapeutic lung resections for primary lung cancer 70-150 per centre. >150 by 2018-19	100%	Trust Reported	GC9
	National Cancer Patient Experience survey	National survey report when published	NHS England	If the provider does not take part they will be required to meet with the commissioners

				to explain reasons for not doing so and activity planned to enable the information to be captured through alternative mechanisms
	Improving Service User Experience	Of responses received 75% should express overall satisfaction with the service. Trust to evidence the measures it has taken to improve service user experience and outcomes achieved and numbers / percentages stratified	NHS England	GC9
Domains 1, 2, 3, 4 & 5	Addressing Complaints	Trust to evidence the measures it has taken to address complaints and outcomes achieved	Trust Reported	GC9
Domains 1, 2, 3, 4 & 5	Patient involvement	Trust to evidence the actions it has taken to engage with patients and demonstrate where this has impacted	Trust Reported	GC9
Domains 1, 2, 3, 4 & 5	Trial Activity; Recruitment into trials	90% of Patients eligible for an existing clinical trial should be offered the chance to be treated in a	NCRN	GC9

		clinical trial		
	Post surgery mortality	Numbers and percentage baseline to be set	Trust Reported	GC9
Domains 1, 2, 3, 4 & 5	30 and 90 day mortality after surgery	Survival figures have been produced for therapeutic lung resections for primary cancer in surgical units, not for individual surgeons. This because the is no reliable method currently available for taking into account the different case mix of patients that individual surgeons operate on. Data shows 98% of patients are alive at 30 days and 96% are alive at 90 days post surgery.		
	Data Submission: Registry dataset submission status	As required by Registry	National Peer Review	GC9
	Data Submission: Staging data	As required by Registry	National Peer Review	GC9
Domains 1, 2, 3, 4 & 5	Data Submission: LUCADA data completeness	>85%	LUCADA	GC9

Appendix Two

Adult thoracic surgery services include all services provided by Adult Thoracic Surgery Centres including outreach when delivered as part of a provider network.
(Manual)

Service Description	Type	NPOC	NCBPS
Adult thoracic surgery services – outpatients	Adult	A14 (Previously A12)	29Z
Complex thoracic surgery			29B

Data Flows

Adult thoracic surgery services – outpatients:

The data flows used to support the service are:

- Outpatient attendances via SUS

Complex thoracic surgery:

The data flows used to support the service are:

- Inpatient activity via SUS
- ITU activity via SUS
- Device details via local data flow
- Drug usage information via local data

How the activity for this service is identified

This service includes ALL activity at specified centres.

How to use the identification rules

1. Outpatient attendances can be identified by using the 173 (Thoracic Surgery) treatment function code
2. Specialised inpatient activity is identified by the presence of the appropriate treatment function codes given in the tool.
3. Based on the output to 1 above, all critical care (unbundled activities) should also be identified.
4. The identification rules identifies that National tariff excluded high cost drugs used to support the clinical management of complex thoracic surgery patients are chargeable to commissioners of prescribed specialised services (see list of chargeable high cost drugs). Trusts are encouraged to use their prescribing systems to identify the amount and cost of drugs used for this patient cohort.
5. The identification rule identifies National tariff excluded devices as being chargeable to commissioners of prescribed specialised services. Trusts are encouraged to contact the clinical service or finance staff to identify the devices and their cost used in the care of these patients.

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