National Optimal Lung Cancer Pathway

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Lung Clinical Expert Group
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Document Title: National Optimal Lung Cancer Pathway and Implementation Guide

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Prepared by:
The Lung Clinical Expert Group, which is chaired by David Baldwin and includes representation from the full range of professions involved in delivering lung cancer services as well as patient groups and commissioners.

Audience:
This document is intended for lung cancer service providers, commissioners and cancer alliances. It will also be of interest to those involved in developing cancer policy.

Groups consulted:
There has been wide consultation on the NOLCP with an early draft having been sent to Lung MDTs across the country. Over 50 responses were received and these were all considered carefully during the revision process. Later drafts were also circulated widely via the Lung CEG and a number of modifications were made in response.

Purpose:
The NOLCP and its accompanying Implementation Guide are designed to help lung cancer service providers and their commissioners to see the basic structure of an effective and efficient lung cancer pathway. There is randomised controlled trial evidence that faster pathways improve outcomes.

The aim of the document is to encourage local services to review and reorganise their services in a way that ensures a fast pathway from referral to diagnosis and then treatment without compromising patient experience. A more streamlined pathway will also ensure a more efficient and effective use of valuable resources.

The NOLCP should be read alongside The NOLCP Implementation Guide, which is available as a separate document.

Executive summary

The National Optimal Lung Cancer Pathway and its accompanying Implementation Guide, provides a road map for service providers and commissioners who are aiming to improve their local lung cancer services.

Although the pathway illustration may appear formal, the implementation guide and the commissioning guidance emphasises the need to use local knowledge to adapt the pathway to local circumstances.

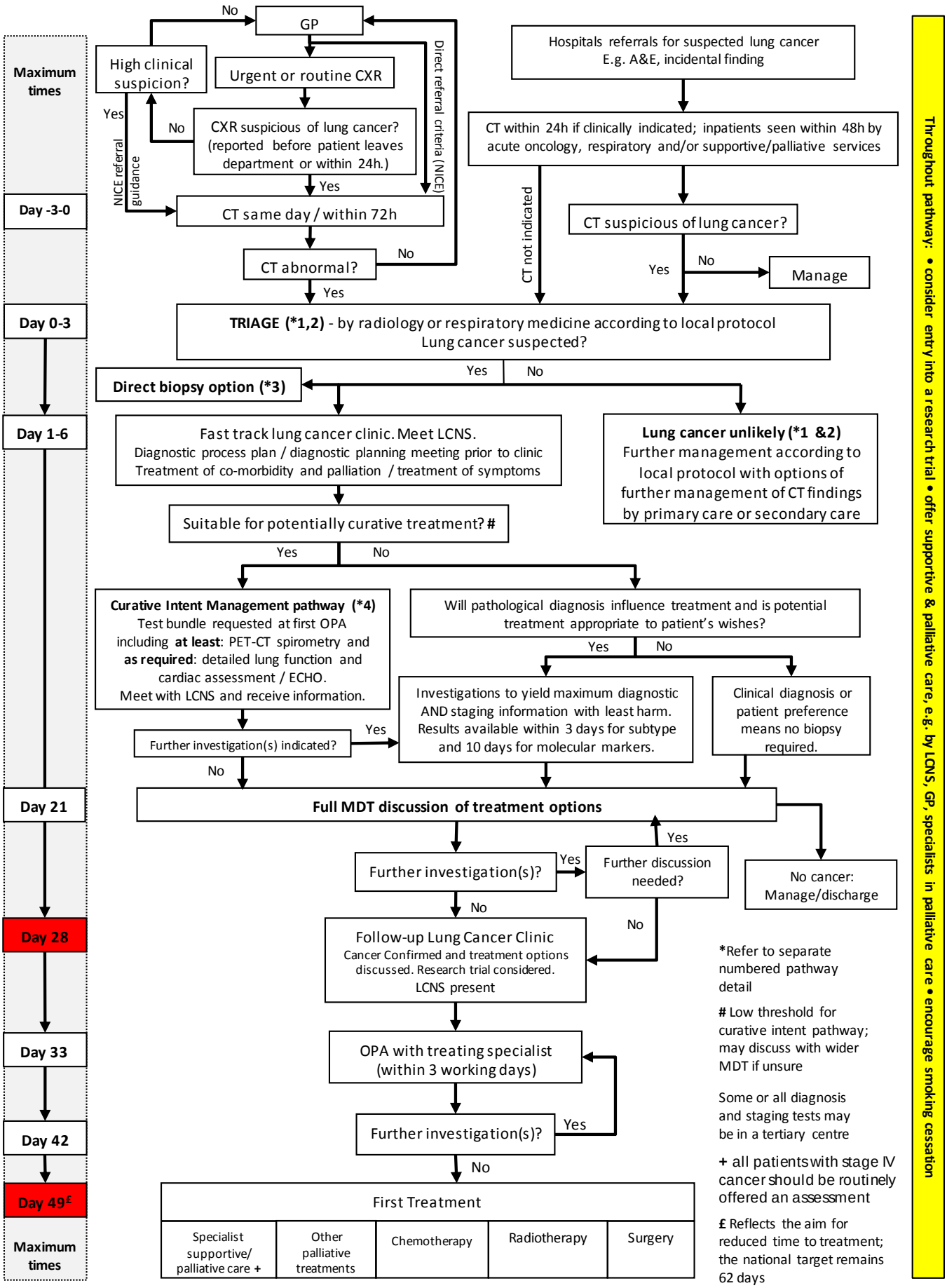
The times in the pathway are recommended and are achievable, even though challenging. The length of the pathway is **49 days** to the start of treatment, even though the national cancer waiting times standard is currently 62 days. The start point of the cancer pathway is the date of referral on to the cancer pathway, or date of upgrade to the cancer pathway once the diagnosis of cancer is suspected; this can be based on chest X-ray or CT.

Key Features of the Pathway include:
- CXR to CT and Clinic in less than 24 hours
- Scope for either primary or secondary care to lead up to triage
- Rapid turnaround times for testing/reporting
- Daily respiratory clinic opportunities
- Direct to biopsy option

The Pathway diagrams that follow include:
- Full Pathway: Referral to Treatment
- Pathway Detail 1: Triage, with secondary care lead
- Pathway Detail 2: Triage, with primary care lead
- Pathway Detail 3: Direct to biopsy variation
- Pathway Detail 4: Curative intent management pathway

Whilst we realise that it will be a challenge to put the NOLCP in place fully, we believe that there is considerable scope to improve current lung cancer pathways and that the NOLCP timings should be what all lung cancer services should aim for. There is evidence that faster pathways will lead to better lung cancer outcomes, including improved survival. Improved patient experience should also be an outcome of NOLCP implementation.

National Optimal Lung Cancer Pathway
For suspected and confirmed lung cancer: Referral to treatment
UPDATE 2017 Version 2.0

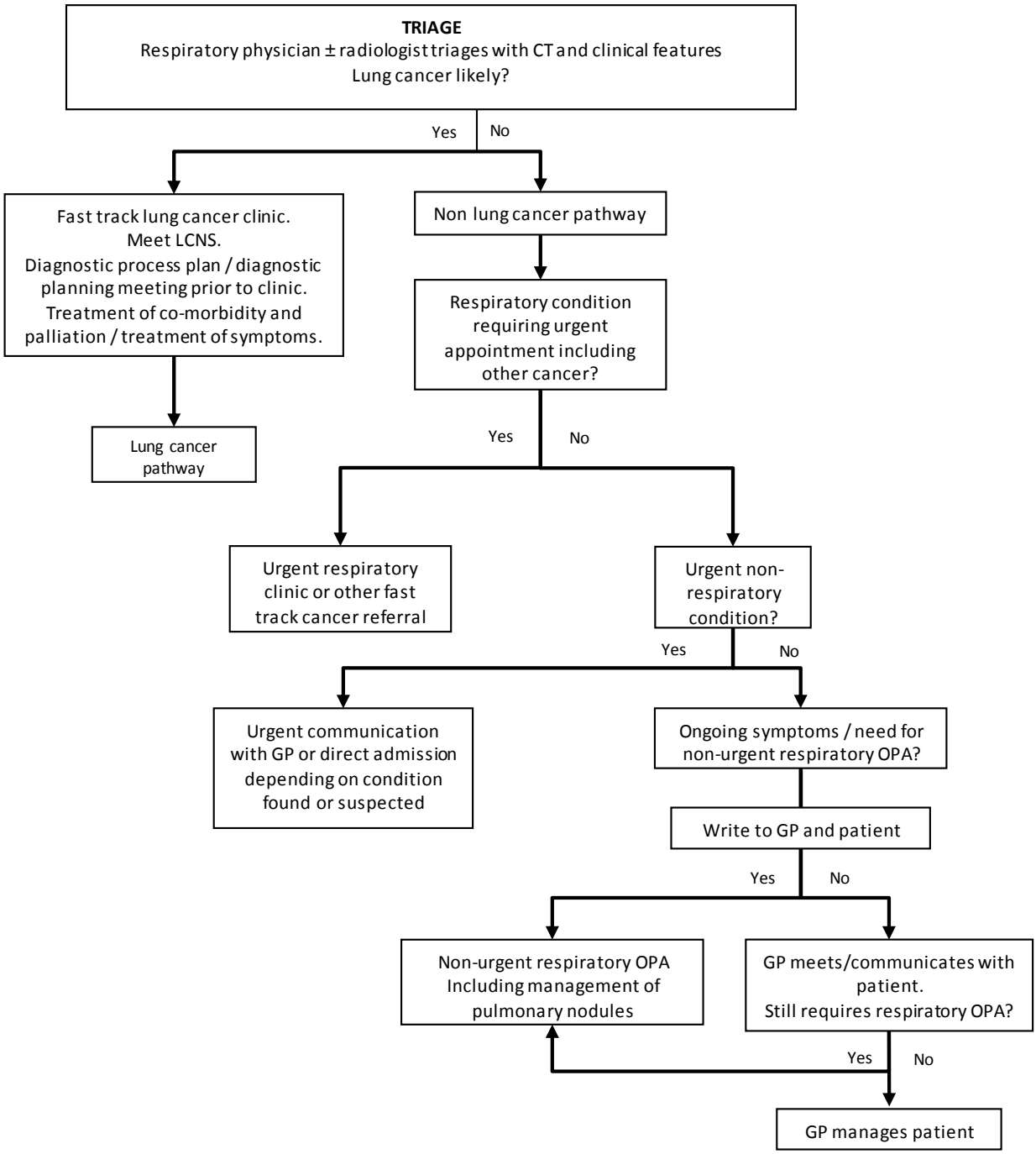


Pathway Detail 1

Triage system for referrals to the lung cancer service: secondary care leads the management process

Triage refers to the process of selecting the appropriate route based on clinical data

This pathway places the responsibility for managing all patients referred for suspected lung cancer within secondary care. It ensures patients with other conditions that may require secondary care are given appointments and patients not requiring secondary care are directed back to primary care.



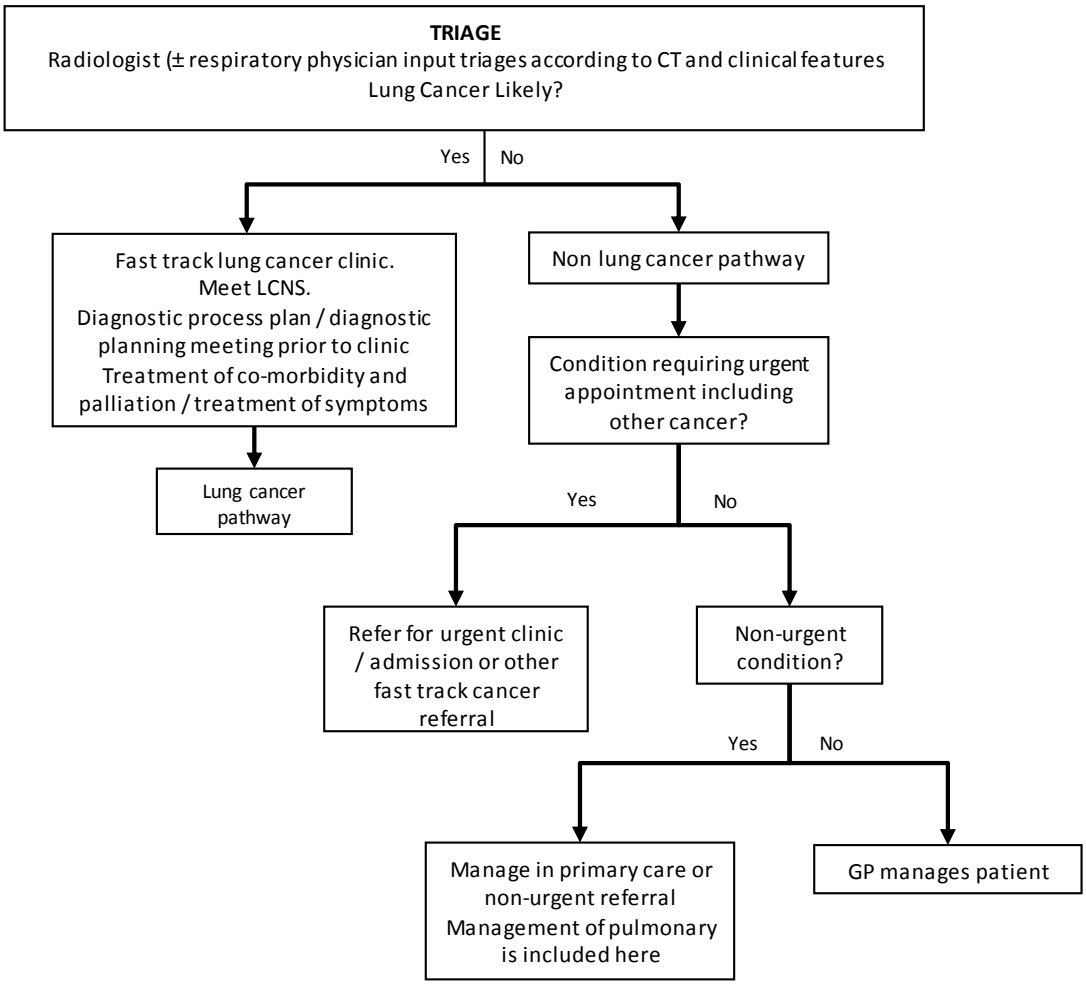
Recommendations for the management of pulmonary nodule can be found in the British Thoracic Society guidelines on the investigation and management of pulmonary nodules.

Pathway Detail 2

Triage system for referrals to the lung cancer service: primary care leads the management process

Triage refers to the process of selecting the appropriate route based on clinical data.

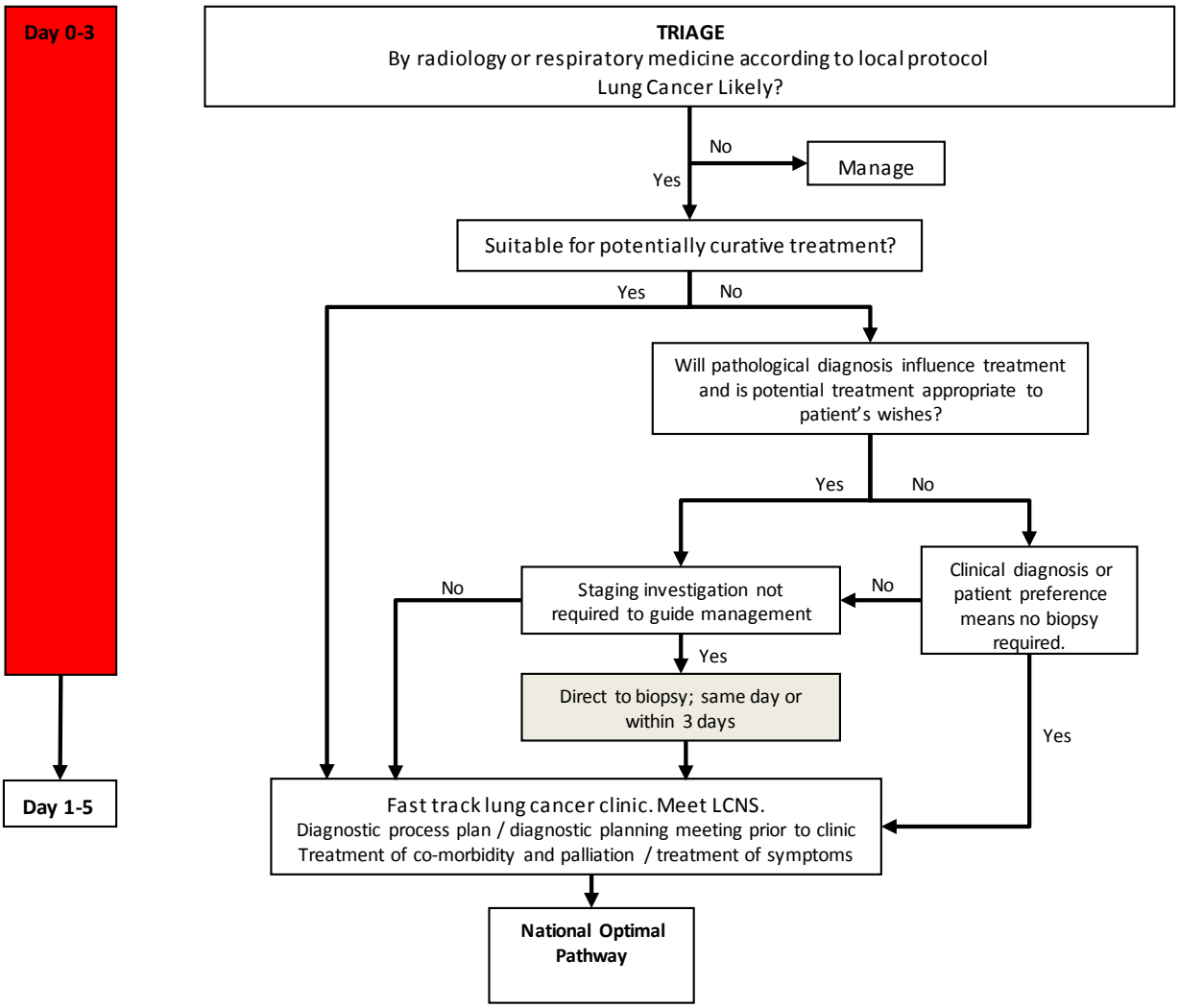
This pathway places the responsibility for managing all patients referred for suspected lung cancer within secondary care. It ensures patients with other conditions that may require secondary care are given appointments and patients not requiring secondary care are directed back to primary care.



Recommendations for the management of pulmonary nodules can be found in the British Thoracic Society guidelines on the investigation and management of pulmonary nodules.

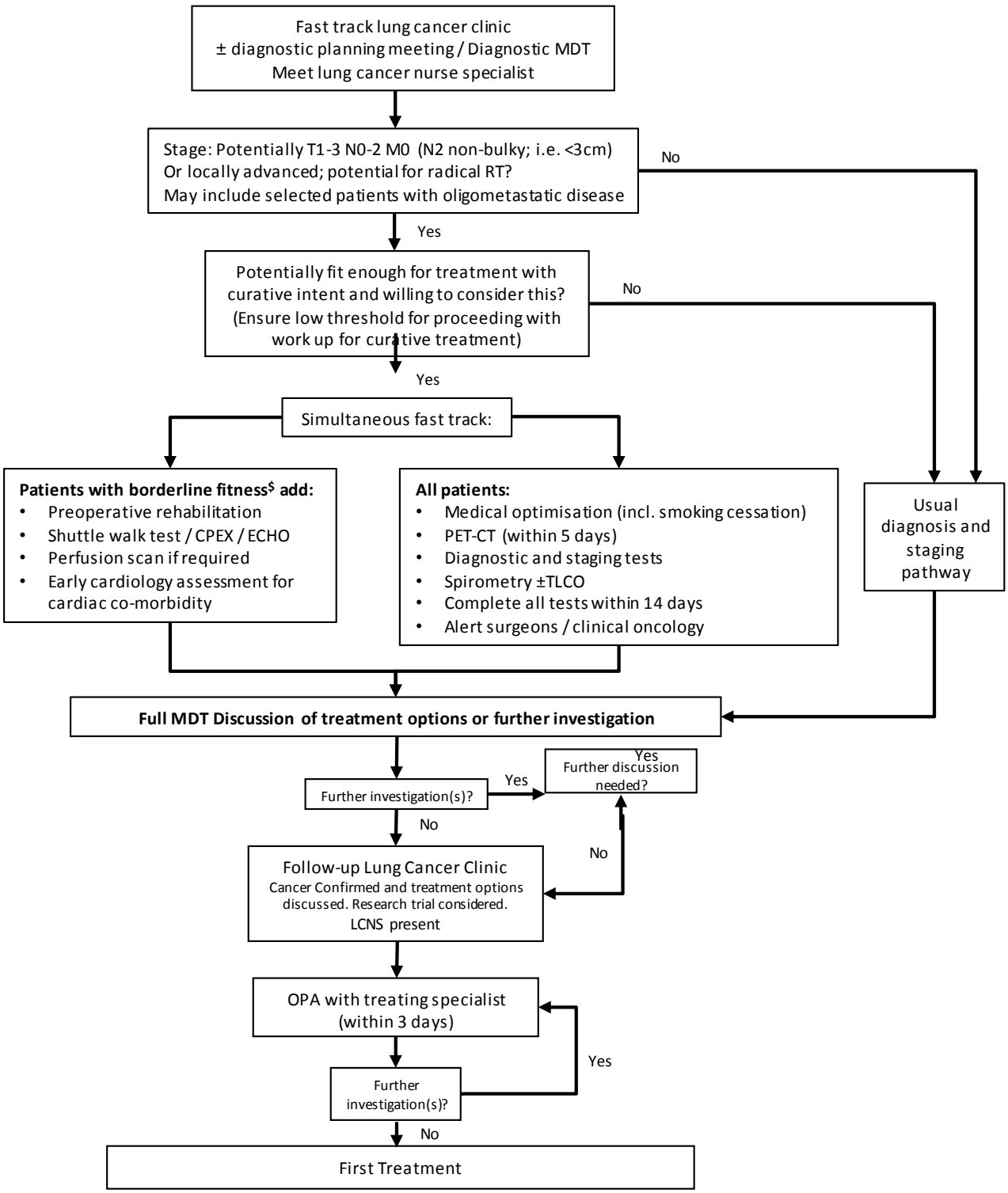
Pathway Detail 3
Direct to biopsy variation

This pathway allows for early diagnostic biopsy where other tests are not required for staging and treatment. Such patients include those that have obvious advanced disease that is not suitable for treatment with curative intent. Patients potentially suitable for curative intent generally require a PET-CT to clarify diagnosis (for small pulmonary nodules) staging and the most appropriate first diagnostic and staging investigation. Direct biopsy investigations include neck ultrasound guided biopsy, percutaneous lung biopsy, endobronchial ultrasound needle biopsy, pleural aspiration and pleural biopsy. The direct biopsy pathway has the potential to provide a rapid diagnosis for some patients where detailed staging and fitness investigations are not needed to guide management.



Pathway detail 4
National Optimum Curative Intent Management Pathway

Patients who are potentially suitable for curative treatment usually require multiple investigations to accurately assess their diagnosis, stage and fitness. The capacity to provide rapid access to these investigations may be limited and so the logistics of scheduling needs to be optimised to prevent long waiting times. This pathway fast tracks these patients by requesting tests concurrently, supported by pre-planned availability of urgent test appointments e.g. lung biopsy, bronchoscopy, endobronchial ultrasound, mediastinoscopy, ECHO and complex lung function. Reference should be made to the British Thoracic Society guidelines for the radical management of lung cancer and the NICE guidelines for the investigation and management of suspected lung cancer. To prevent delays in treatment, consider early notification of thoracic surgeons or clinical oncology to help with scheduling.



$There is no agreed definition of borderline fitness. NICE QS 17 (Lung Cancer) defines this as a level of fitness that could lead to a greater than average morbidity or mortality from surgery. However, modern radiotherapy techniques mean that assessment for curative treatment can be applied at lower levels of fitness than defined in QS17.