

Measures in GIRFT report aim to ensure faster diagnoses and more effective treatment for patients with lung cancer

A new national report from the Getting It Right First Time (GIRFT) programme highlights measures that will help prolong the lives of more lung cancer patients in England, by enabling faster and more precise diagnoses and delivering more effective treatment.

Commissioned jointly with the NHS England National Cancer Programme and in line with the ambitions of the NHS Long Term Plan, the GIRFT report outlines measures which can improve on the current 16% of people who are still alive five years after their lung cancer diagnosis.

Lung cancer is the second most common cancer in men (after prostate) and women (after breast), with around 48,000 patients diagnosed each year in the UK. Because the symptoms are similar to those of other respiratory conditions patients often present at a late stage of the disease, making lung cancer the most common cause of cancer death, killing 35,000 people annually.

While five-year survival rates are steadily improving, outcomes for lung cancer in the UK still lag behind those in other comparable countries.

The GIRFT report is authored by an expert team* of respiratory physicians, nursing specialists and an oncologist, who work first-hand with patients every day. Based on in-depth data and discussions with lung cancer teams in trusts across England, it makes 33 recommendations across the whole cancer pathway – from the point of initial assessment to end of life care or cure – focusing particularly on measures which can improve patient experience and outcomes.

Examples include:

Making a rapid and precise diagnosis: Delays of just a few days can affect the long-term survival of lung cancer patients. The GIRFT team found variation between trusts in the time taken to complete all stages of the patient pathway – for example, the time between a patient's first CT scan and a decision being made about their treatment can vary by almost two weeks.

The GIRFT report highlights best practice and offers practical solutions for trusts to implement through a series of recommendations. These include a call for the national contract for positron emission tomography (PET) scans to be re-negotiated to mandate a five-day turnaround from request to report for new diagnoses of lung cancer.

Noting significant variation in access to image-guided biopsies between trusts, the team are also calling for these procedures to be available for all patients 52 weeks of the year, with appointments within five days of request.

Delivering effective treatment: For lung cancer survival rates to improve, more patients need to be offered curative-intent/radical treatments (aiming to 'cure' or eliminate cancerous cells),

including surgery and radiotherapy. Diagnosing the disease at an early stage is a critical part of this ambition, and the GIRFT team strongly supports the introduction of a national risk-based screening programme to reach people most likely to have lung cancer in its early stages.

GIRFT's review also showed that the proportion of early stage patients accessing radical therapy can vary significantly between trusts. The report recommends that an overall radical treatment rate of 85% or more of suitable patients should be targeted by all trusts – which would mean additional 416 patients could receive potentially life-saving treatment each year.

In addition to recommendations concerning diagnosis and treatment, the GIRFT report outlines how multidisciplinary working can be improved to be as timely, efficient and effective as possible and meet the needs of patients, as well as steps for improving data and information and tightening up organisation and accountability in lung cancer services. The recommendations are endorsed by five leading professional societies and colleges: Lung Cancer Nursing UK, the British Thoracic Society, the Society for Cardiothoracic Surgery, the British Thoracic Oncology Group and the Royal College of Physicians.

Co-author Dr Paul Beckett, a consultant respiratory physician at University Hospitals of Derby and Burton NHS Foundation Trust, said: "We have tried to ensure that patients are at the heart of our recommendations, and for that reason it is important that they must not remain as ink on a page but are considered and implemented at local, regional, and national level by those responsible for commissioning and delivering services."

Dr Elizabeth Toy, a consultant clinical oncologist at the Royal Devon and Exeter Foundation NHS Trust, added: "We are grateful to our lung cancer colleagues up and down the country for their welcoming approach to our review of services, particularly given what a difficult year 2020/21 has been with the impact of COVID-19 on clinical teams' workload. We are confident that everyone will rise to the challenge and implement these important recommendations for the benefit of patients."

***About the authors**

The report has five GIRFT authors:

Clinical leads

Dr Paul Beckett: consultant respiratory physician at University Hospitals of Derby and Burton NHS Foundation Trust

Dr Elizabeth Toy: consultant clinical oncologist based at the Royal Devon and Exeter Foundation NHS Trust

Dr Sarah Doffman: respiratory physician and past chair of the Sussex Cancer Network Lung Tumour Group

Lung cancer nursing specialist leads

Victoria Anderson: LCNS at Newcastle upon Tyne Hospitals NHS Foundation Trust

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Report recommendations

Making a rapid and precise diagnosis

1. Respiratory teams to immediately move to providing proactive management of unexpected abnormal chest radiology and work with radiology departments to implement pathways that deliver a three working day turnaround from abnormal chest X-ray or referral to CT scan report.
2. Key diagnostic investigations should be completed within 21 calendar days of the start of the pathway by adopting best practice recommendations on service configuration and pathway planning.
3. Renegotiate the national PET-CT contract to include a five calendar day turnaround from request to report and available imaging for initial investigations of new diagnoses of lung cancer.
4. An image-guided biopsy service should be available for all patients 52 weeks of the year, with appointments for the procedure being available (notwithstanding issues such as anti-coagulation or anti-platelet therapy) within five working days of the request.
5. EBUS for lung cancer should be available within five calendar days of request and must comply with the national service specifications, with regular monitoring of performance by local commissioners.
6. Ensure a diagnostic and therapeutic ambulatory pleural service is available for all lung cancer patients, accessible within five working days, 52 weeks of the year.
7. Pathological services should provide a maximum ten calendar day turnaround time for molecular profiling according to the national test directory of lung cancers to meet the requirements of the NOLCP.
8. Commission a specific, robust and predominantly virtual nodule pathway which is separate from the lung cancer MDT/MDM.

Delivering effective treatment

9. 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. This includes all treatment modalities (surgery, radiotherapy including SABR, multimodality treatment and thermoablative techniques).
10. All trusts should have an overall surgical resection rate for NSCLC of over 20%.
11. All trusts that treat lung cancer with radiotherapy should be able to deliver SABR in line with the clinical commissioning policy.
12. All trusts should deliver radiotherapy in line with the Royal College of Radiologists

consensus statements.

13. 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.

14. Trusts should monitor rates of post-surgical adjuvant and neoadjuvant treatments and this data should be available for national benchmarking.

15. Trusts should record and monitor multimodality treatment in stage IIIA disease and offer radical intent treatment as standard in fit patients.

16. 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.

17. 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.

18. 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.

19. Produce and implement protocols for follow-up pathways following radical therapies.

20. Clinical trial recruitment should be considered a focus for prioritisation, with MDTs collaborating to offer a wider regional portfolio.

Effective multidisciplinary working

21. Review operational arrangements for multidisciplinary working to ensure it is as timely, efficient, and effective as possible and meeting the needs of patients.

22. Improve timeliness and effectiveness of communication from the MDT to lung cancer patients and primary care.

Improving data and information

23. Continue the NLCA in the long-term in order to quality assure and improve services and bring the clinical community together with a shared purpose.

24. Monitor and performance manage trusts according to the key time points within the NOLCP.

25. Collect, analyse and publish an agreed EBUS dataset aligned to agreed performance metrics and standards.

26. Improve the annual review of data within lung cancer services.

27. Develop more relevant and generalisable methods of collecting data on patient-reported experience and outcomes.

Resources, organisation and accountability

28. Ensure all lung cancer MDTs have a named clinical lead for the service, with job planned time for the role to allow for service development and management.
29. Ensure all lung cancer MDTs have appropriately skilled practitioners across the whole range of medical, nursing and allied health professions and healthcare scientists, able to give the same levels of high-quality care to all patients in all areas of the country 52 weeks of the year.
30. Review the process for funding allocations to ensure that transformation funding is used as effectively as possible.
31. Roll out national implementation of risk-based CT screening for lung cancer.
32. Ensure that a clinical reference group continues to be available to provide strategic and clinical advice.

COVID-19 and lung cancer

33. National bodies and local lung cancer services should continue to respond to the challenges presented by the COVID-19 pandemic.