Specialised Services Service Specification:

Thoracic Surgery

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**Thoracic Surgery Service Specification**  
Version: 1.0  

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.
1. Aim

1.1 Introduction

The purpose of this document is to define the service specification for the provision of thoracic surgery for adult patients resident in Wales.

The objectives of this service specification are to:

- Describe the service model and pathway required to ensure the highest quality, safe, sustainable and equitable thoracic surgery service is provided for the population of Wales;
- Set out the level of service that patients and their families can expect to receive;
- Specify the quality standards and indicators that must be achieved;
- Ensure that the needs and experience of patients, families and carers are integral to the delivery of the thoracic surgery service for Wales.

1.2 Background

South Wales has a legacy of heavy industry and coal mining; both of which contribute significantly to lung disease. Primary lung cancer, related to tobacco is the commonest cause of cancer death in Wales. However, the population in Wales has a poor survival rate for lung cancer compared to the UK, the rest of Europe and the USA. Surgery is known to provide the best chance of survival. However, patients often present with advanced disease making surgery less likely to be suitable or successful. It is therefore essential that cases are detected early in order to provide the best prognosis.

In Wales, lung cancer incidence rates vary across the seven Health Boards. The highest overall incidence rate is in Cwm Taf UHB which is two-thirds higher than the lowest in Powys. Geographical differences in lung cancer across Wales are primarily due to historic trends in smoking and exposure to tobacco smoke, especially in areas of deprivation (WCISU, Public Health Wales 2015)
There are two types of lung cancer: Non Small Cell Lung Cancer (NSCLC), which accounts for 90% of lung cancers, and Small Cell Lung Cancer (SCLC). There are three common sub-types of NSCLC: squamous cell carcinoma, large cell carcinoma and adenocarcinoma.

The lung cancer resection rate in Wales is lower than in many other parts of the UK. The National Lung Cancer Audit has demonstrated that there is wide variation in surgical resection rates across the UK. Patients are more likely to have surgery for lung cancer if they present to a hospital that provides thoracic surgery on site as this is thought to represent easier access to specialist thoracic surgeons.

In addition to the treatment of lung cancer, there are many other conditions which require thoracic surgery. These 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

1.3 Relationship with other Policy and Service Specifications

This document should be read in conjunction with the following documents:

- Commissioning policy for PET-CT
- Commissioning Policy for Stereotactic Ablative Body Radiotherapy for the Management of Surgically Inoperable Non-Small Cell Lung Cancer in Adults.

2. Service Delivery

2.1 Definition of Thoracic Surgery

Thoracic Surgery is concerned with the diagnosis and surgical treatment of a range of diseases and conditions of the chest. These structures include:

- the airway
- lungs
- pleura
- mediastinum
- chest wall
- diaphragm
Thoracic Surgery excludes surgery on the heart and great blood vessels, which is undertaken by Cardiac Surgeons, and surgery of the oesophagus, which is undertaken by Upper Gastrointestinal Surgeons.

A general thoracic surgeon will operate to treat the following indications:

**Cancer**
- Lung cancer
- Mesothelioma
- Mediastinal malignancy
- Lung metastasis from non lung cancer primaries

**Non Cancer**
- Severe emphysema
- Empyema
- Chest wall deformity
- Primary and secondary pneumothoraces
- Diagnostic lung biopsies
- Air leak
- Chest trauma

This specification excludes lung transplantation which is undertaken in designated units in England under standards set by NHS England.

### 2.2 Aims of Thoracic Surgery

The Thoracic Surgery service set out in this specification aims to:

- Where possible, provide curative treatment for patients with lung cancer;
- Increase survival for patients with lung cancer;
- Where possible, provide curative treatment for non cancer conditions;
- Maximise patients’ functional capability and quality of life;
- Provide patient centred care and optimise the quality of patient and family experience;
- Provide access to the highest quality surgical practice, including new surgical techniques, based on robust evidence and best practice guidance;
- Provide a service that is equitable;
- Provide a service that is sustainable;
• Provide timely access to treatment and achieve mandated waiting time targets;
• Provide a service seamlessly integrated into referral pathways with secondary care and inter-dependent services.

2.3 Service Provision

The thoracic surgery service will include the following infrastructure and service components:

• Thoracic surgery unit
  o The thoracic surgery service will have designated resources:
    ▪ Dedicated thoracic surgery ward beds
    ▪ Dedicated thoracic surgery theatre/s
    ▪ Dedicated thoracic surgery HDU (level 2) and access to ITU (level 3)

• Out-patient clinics
  o Patients will be assessed for their suitability for thoracic surgery, receive pre-operative/pre-admission assessment and post operative follow up, in dedicated thoracic surgery clinics.
  o Thoracic surgery outreach clinics will be established in each Health Board for assessment of suitability for surgery, pre-operative/pre-admission assessment and post operative follow up, for the convenience of patients and families to maximise accessibility.

• Inter-dependent services
  The thoracic surgery service must have access to the following services. It is anticipated these services will usually be co-located with the thoracic surgery service.

  o Respiratory medicine
  o Haematological biochemical and microbiological laboratories
  o Respiratory pathology laboratory
  o Endoscopic examinations by bronchoscopy and oesophagoscopy (including endobronchial ultrasound and endoscopic ultrasound)
  o Radiological investigation by plain X-ray, contrast studies, ultrasound needle biopsy, vascular imaging and computed tomography (including PET CT)
o Cytology, histopathology and frozen section analysis of intra-operative specimen, the results of which should be communicated with the operating surgeon within 1 hour of the sample being taken.

o Support from all other hospital services especially interventional radiology and pulmonary rehabilitation.

- Other co-located services
  o The thoracic surgery service will benefit from co-location with cardiac surgery:
    ▪ To share cardiothoracic trainees
    ▪ Operational efficiencies from pool of support staff skilled in both thoracic and cardiac surgery.

- Thoracic emergencies and out of hours service
  o The service will provide 24/7 emergency cover by general thoracic surgical consultants (with or without mixed-practice cardiothoracic surgical colleagues).
  o The surgeons on the rota should be able to deal with the full range of thoracic surgical emergencies.
  o Cross cover of rotas from consultants with a purely cardiac practice or from consultants from other specialities is unacceptable.
  o The service will ensure that there is 24/7 cover of thoracic surgical inpatients. This may be delivered with support from surgical trainees, speciality doctors and appropriate trained advanced care practitioners.

- Lung Cancer Multi-Disciplinary Team Meetings
  o Thoracic surgeons are core members of the Lung Cancer MDT. All patients referred to thoracic surgery for further assessment of suitability for surgical resection of lung cancer must be referred through the Lung Cancer MDT.
  o The thoracic surgery service will ensure that thoracic surgeons’ job plans include sufficient allocation for Lung Cancer MDT meetings, including cross cover for annual leave, study leave or sickness. While surgeon attendance at the MDT in person is desirable, video conference linkage from the surgeon’s base hospital is an acceptable alternative.
MDTs should have in place access to the full range of radiology facilities and the technology to facilitate the electronic transfer of images between the referring hospital and the thoracic surgery centre.

### 3. Quality and Patient Safety

#### 3.1 Quality and Patient Safety

- Providers are expected to immediately (within 24 hrs) provide information to WHSSC on the following:
  - Serious Untoward Incidents
  - Serious complaints
  - Issues which may gather media or political interest.

- The providers must work to the quality standards as stated in 3.2 of this document.

- The thoracic surgery service is underpinned by the quality standards as outlined in the NICE Quality Standard for Lung Cancer and the Thoracic Society for Cardiothoracic Surgery in the UK Guidelines for radical management of patients with Lung Cancer.

- The providers are expected to participate in relevant national audits, including the National Lung Cancer Audit.

- The providers are expected to participate in peer review of lung cancer services.

#### 3.2 Quality Indicators (Standards)

The Provider must work to the following quality standards:

##### 3.2.1 Thoracic Surgery Unit

- Thoracic surgery must be performed by qualified surgeons who have full GMC Registration with a licence to practice, and specialised in general thoracic surgery in accordance with National and European regulations.
• A surgeon practising in thoracic surgery must have extensive and updated knowledge of all aspects of pathophysiology, epidemiology, diagnosis, perioperative, intraoperative and postoperative care of patients with surgical disease of the chest.

Minimum volumes
• The thoracic surgery unit should undertake a minimum of 150 primary lung resections per year.

• The thoracic surgery unit should have a minimum of 3 full time general thoracic surgeons.

• Thoracic surgery units should have access to dedicated high dependency beds. There should be access to the Intensive Care Unit (ITU) when necessary.

Organisation
• Thoracic Surgery should be identified as a separate service line within the hospital’s directorate management structure.

Outpatient Facilities
• Thoracic Surgery Units should have sufficient facilities for outpatient visits including facilities for pre-op assessment and preadmission.

• The unit should have the capability of allowing same day access to radiology, pulmonary function tests, endoscopy and cardiological testing if needed.

• 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

Outreach Services
• For those hospitals without on-site thoracic surgery it is essential that the populations served 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.
• Services in outreach clinics should be of the same high standard as at the tertiary centre, including provision of information and support.

Second Opinion Process
• The service will put arrangements in place to provide a second opinion:
  o Any patient with borderline resectability and acceptable fitness for surgery, and not initially accepted for surgery, should be offered a second opinion through an alternative MDT.
  o In accordance with NICE guidelines for patients with lung cancer, any patients with a resectable lung cancer who are of borderline fitness and not initially accepted for surgery, should be offered the choice of a second surgical opinion and a multidisciplinary team opinion on non surgical treatment with curative intent.

Pre-habilitation and Enhanced Recovery
• Pre-habilitation is a service which aims to ensure patients are in a fit state prior to surgery.
• Patients with a resectable lung cancer who are of borderline fitness for surgery should be offered the opportunity to engage in a pre-habilitation programme prior to referral to thoracic surgery.
• There should be clear pathways established in the thoracic surgery units to provide an enhanced recovery programme. Enhanced recovery programmes are usually supported by physiotherapy, dietetics and nursing staff.
• Enhanced recovery pathways enable patients to recover at a faster pace from major surgery and should be adopted by the thoracic surgery centre.

The Care Team
• Consultant-led care by general thoracic surgeons, with or without surgeons with a mixed cardiothoracic practice\textsuperscript{1}
• Surgical trainees
• 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

\textsuperscript{1} It is recognised that dual cardiothoracic practice is in the process of being phased out in England. Within the next few years, it is anticipated that thoracic surgery will be delivered by full time general thoracic surgeons only.
- Thoracic nurse specialist support in all areas
- Lung cancer nurse specialist support in thoracic surgical clinics and wards
- Specialised thoracic physiotherapy (including out of hours and at weekends)
- Specialist support in post operative pain control
- Access to specialist palliative care
- A designated pathologist
- Designated administrative staff to ensure all clinical staff are supported in the timely delivery and monitoring of the service
- Case managers

Follow up
- Patients should be offered a specialist follow up appointment within 6 weeks of surgery (3 weeks for oncological patients) and regular specialist follow up thereafter, which may be delivered within a local setting and include a protocol led clinical nurse specialist follow up.
- A system of follow up appointments at outpatient and peripheral clinics should be in place.
- There should be rapid and comprehensive feedback to referral teams including the patients GP to ensure that as much follow up care as possible can be provided locally.
- There should be an agreed referral process back to the centre for patients requiring specialist advice or support. Urgent cases should be on an immediate basis. Failure to attend an appointment without explanation should be followed up.

Emergency cover and on-call arrangements
- Providers are required to have 24/7 emergency cover by general thoracic surgical consultants with or without mixed-practice cardiothoracic surgical colleagues.
- 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 specialities is unacceptable.
- A sustainable on call rota should not be more frequent that 1 in 4.

Holistic Needs Assessment
- As recommended by NICE guidelines, patients with lung cancer should be offered a holistic needs assessment at each key stage of care that informs their care plan and the need for referral to
specialist services. The holistic needs assessment is usually carried out by the clinical nurse specialist.

Palliative Care
- All services caring for patients with progressive life threatening disease have a responsibility to provide care with a palliative approach.
- All patients should have access to specialist palliative care services as described in the CSCG Minimum Standards for Specialist Palliative Care (NHS Wales 2005).

Patient experience
- All patients must be given details of their Key Worker and how to contact their key worker at all stages of their treatment. Support and counselling should be available, either personally or by telephone.
- Feedback from patients regarding their experience must be gained in a structured manner at least annually and reported to WHSSC. This feedback may also be used to make service change where required.
- The centre must enable the patient’s, carer’s and advocate’s informed participation and to be able to demonstrate this. Provision should be made for patients with communication difficulties.

Clinical Trials
- Patients should be given the opportunity to enter approved clinical trials for which they fulfil the entry criteria.

Education, training and research
- Providers of thoracic surgery should be linked to a University.
- There must be programmes for ongoing education and development for all professionals involved in the service.
- Providers are expected to offer programmes for ongoing education and development for all professionals involved in the service. There should be an ongoing programme for research activity in line with research governance requirements.

Referral Links for patient support
- There should be close links with support services such as social workers, psychiatrists, chaplain, bereavement support and the primary health care team.
3.2.2 Timely access to treatment

The following targets should be achieved:

- **Cancer waiting time targets**
  - Urgent Suspected Cancer: treatment within 62 days of referral from Primary Care.
  - Non Urgent Suspected Cancer: treatment within 31 days of the decision to treat.

- **The results of cytology, histopathology and frozen section analysis of intra-operative specimens, should be communicated to the operating surgeon within 1 hour of the sample being taken.**

- **Urgent (non cancer) in-patient treatment:**
  - Indications for urgent treatment (such as empyema or pneumothorax) often requiring in-patient transfer from General Hospitals to the thoracic surgery unit:

- **Transfer to the thoracic surgery unit and treatment within 48 hours of referral.**

- **Patients with non malignant conditions on elective referral pathways should be treated within the referral to treatment targets for Wales:**
  - 95% within 26 weeks from GP referral to treatment
  - No patient should wait in excess of 36 weeks from referral to treatment.

- **Where there is a clinical suspicion of malignancy, patients referred for a diagnostic biopsy of lung or mediastinal lymph node should have this performed within a clinically appropriate timeframe. The time from referral for diagnostic biopsy to performing the biopsy for these patients will form part of the performance monitoring of the service.**

3.2.3 Responsibilities of referring Health Boards

It is important to recognise the key role of referrers in enabling the thoracic surgery service to achieve the quality standards in this specification. This includes the timely assessment and referral of patients, the provision of full diagnostic information and repatriation of patients back to secondary care once the tertiary service is no longer clinically required.
4. Putting Things Right: Raising a Concern

Whilst every effort has been made to ensure that decisions made under this policy are robust and appropriate for the patient group, it is acknowledged that there may be occasions when the patient or their representative are not happy with decisions made or the treatment provided. The patient or their representative should be guided by the clinician, or the member of NHS staff with whom the concern is raised, to the appropriate arrangements for management of their concern:

- When a patient or their representative is unhappy with the decision that the patient does not meet the criteria for treatment further information can be provided demonstrating exceptionality. The request will then be considered by the All Wales IPFR Panel.

- If the patient or their representative is not happy with the decision of the All Wales IPFR Panel the patient and/or their representative has a right to ask for this decision to be reviewed. The grounds for the review, which are detailed in the All Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR), must be clearly stated. The review should be undertaken, by the patient's Local Health Board;

- When a patient or their representative is unhappy with the care provided during the treatment or the clinical decision to withdraw treatment provided under this policy, the patient and/or their representative should be guided to the LHB for NHS Putting Things Right. For services provided outside NHS Wales the patient or their representative should be guided to the NHS Trust Concerns Procedure with a copy of the concern being sent to WHSSC.
5. Performance Monitoring and Information Requirements

5.1 Performance Monitoring

WHSSC will be responsible for commissioning services in line with this specification. This will include agreeing appropriate information and procedures to monitor the performance of organisations.

- Service providers to evidence quality and performance controls and procedures.
- Service providers to evidence compliance with standards of care.

WHSSC will conduct performance and quality reviews on an annual basis.

5.2 Key Performance Indicators

The providers will be expected to monitor against the following target outcomes:
- Cancer Waiting Times
- Referral to Treatment waiting times
- Thoracic surgery component waiting times for patients on cancer and elective pathways.
- Urgent treatment/transfer times (non cancer indications)
- Resection rates by MDT
- Thoracic surgeon attendance at Lung Cancer MDT
- Intra-operative pathology results
- Length of stay for patients having lung surgery – cancer and non cancer

- Outcomes specified by the Society for Cardiothoracic Surgeons for submission to the SCTS Thoracic Surgical Database:
  - Post operative mortality
  - Post operative complications
  - Air leak after lung resection for primary cancer
  - Return to theatre
  - ITU readmission
  - Need for ventilation
Cancer Waiting Times
Providers are expected to comply with the cancer waiting times in Wales, these are:

a) Newly diagnosed cancer patients that have been referred as Urgent Suspected Cancer (USC) should start definitive treatment within 2 months (62 days) from receipt of referral at the hospital.

b) Newly diagnosed cancer patients not included as USC referrals to start definitive treatment within 1 month (31 days) of a decision to treat.

Referral to Treatment Waiting Times
Referral to Treatment Time (RTT) is the period of time from referral by a GP or other medical practitioner to the start of definitive treatment.

The RTT waiting times for patients in Wales are:
- 95% of patients waiting less than 26 weeks from referral to treatment; and
- 100% of patients treated within a maximum of 36 weeks.

Urgent treatment (non cancer indications)
- Indications for urgent treatment (such as empyema or pneumothorax) often requiring in-patient transfer from General Hospitals to the thoracic surgery unit:
  - Transfer to the thoracic surgery unit and treatment within 48 hours of referral.

Intra-operative results
- The results of cytology, histopathology and frozen section analysis of intra-operative specimens, should be communicated to the operating surgeon within 1 hour of the sample being taken.

Length of stay
- Average length of stay for patients admitted for primary lung cancer resection and average length of stay for patients admitted for non cancer thoracic surgery.

Resection rates by MDT
- Reported annually through the National Lung Cancer Audit.
• Providers should ensure that all data items required for cancer registration are correctly recorded in the patient record and coded in accordance with national coding standards. This dataset should be transmitted to the Welsh Cancer Intelligence and Surveillance Unit (WCISU) within an agreed time frame.

**Thoracic surgeon attendance at Lung Cancer MDT**

• The number and proportion of Lung Cancer MDT meeting attended by a consultant thoracic surgeon (either in person or via VC), by MDT in Wales.

**SCTS outcomes**

• Units should report all cases to the UK Registry for thoracic surgery (SCTS) as specified by the Registry. Information from the registry should be analysed and given to every surgeon who undertakes work for the unit.
6. Monthly Performance Data Submission

Every month providers should send to WHSSC by email Cancer Waiting Times, RTT waiting times and activity (number of operations by casemix) performance. It is the provider’s responsibility to notify WHSSC as the commissioner should there be any breaches of the waiting times targets.

6.1 Cancer Waiting Times

Performance against cancer waiting times targets should be submitted to WHSSC on the first working day of each month. For all patients who receive a primary lung cancer resection:

- LHB of residence, Referring MDT, date of referral for surgery, date of out-patient appointment, date of surgery
- Where cancer waiting times targets are not achieved, a breach report will be submitted (inc. the reason for breach and action taken).

6.2 RTT Waiting Times

These should be submitted to WHSSC via the NWIS monthly submission route on the 10th working day of the month.

Profile of the number of patients on an RTT pathway:

- < 26 weeks for surgery
- Between 26-35 weeks for surgery
- >36

The provider should also monitor the appropriateness of referrals into the service and provide regular feedback to referrers on inappropriate referrals, identifying any trends or potential educational needs.
6.3 Activity

Surgical activity, out-patient and in-patient, by indication for surgery, will be reported to WHSSC on a monthly basis.
7. Equality Impact and Assessment

The Equality Impact Assessment (EIA) process has been developed to help promote fair and equal treatment in the delivery of health services. It aims to enable Welsh Health Specialised Services Committee to identify and eliminate detrimental treatment caused by the adverse impact of health service policies upon groups and individuals for reasons of race, gender re-assignment, disability, sex, sexual orientation, age, religion and belief, marriage and civil partnership, pregnancy and maternity and language (welsh).

The Equality Impact Assessment of this specification will be included within the wider Equality Impact Assessment that will be undertaken as part of the Review of thoracic surgery in Wales. The outcome of the wider EIA will inform the development of recommendations regarding the future provision of thoracic surgery in Wales.