The Thoracic Society of Australia & New Zealand
LEADERS IN LUNG HEALTH

The Royal Australian and New Zealand College of Radiologists

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Australian and New Zealand Society of Thoracic Radiology

SITE CHECK LIST IN PREPARATION FOR NLCSP

on behalf of the TSANZ Lung Cancer Working Group and the Australian and New Zealand Society of Thoracic Radiology and the Royal Australian and New Zealand College of Radiologists

The following document is designed to act as a template and catalyst for planning within hospitals and local health authorities for implementation of the National Lung Cancer Screening Program (NLCSP) in 2025. It is not necessarily comprehensive and may not reflect nuances and differing requirements of lung cancer services.

☐ **Early engagement with Hospital Executive and Clinical Excellence teams**

☐ **Assess current service numbers and performance against CQIs[1]**

☐ **Estimating impact on services**

- Engage local Department of Health modelling teams to estimate potential eligible numbers within your region
- Break down by catchment area
- Stratify by estimated screening uptake (20%, 30%, 40%)
- ILST data demonstrates ~2.7% of those screened will have a high-risk nodule[2]
- Approx 50% of high-risk (Cat 5/6) referrals from the NLCSP will have lung cancer[2]
- Note: Depending on referral pathways, local primary care support and uptake of ad hoc screening – there may be more nodules referred from outside the NLCSP.

☐ **Staffing & infrastructure impact to consider:**

- Table 1 provides a summary to consider
- Note the Optimal Care Pathway guidelines for core staffing of thoracic cancer MDT[3]
- In addition to table 1, consider need for lung cancer nurse navigators and coordination of rural / remote cases
- Increased outpatient demands should include administration staff and medical records

☐ **Liaison with finance teams**

- A Nodule MDM and thoracic cancer MDM may be considered a 'Multidisciplinary Case Conference' (MCC)
- Under ABF, 3 specialists are required for a MCC (patient not present)
  - Approved by IHPA
  - Tier 2 code 20.56 = $396 per patient (as of Dec 2024)
  - There are important clinical documentation requirements to note
  - See **Business case template** and background information for Specialist Nurse(s)

BUSINESS CASE TEMPLATE

Respiratory	• Dedicated nodule assessment protocol and clinic • Nodule Multidisciplinary Meeting (discrete from thoracic cancer MDM) • Increased outpatient demands with Cat 5 & 6 referrals and additional findings • Increased survivorship appointments (post treatment)
Radiology	• LDCT scanning capacity (screening, interval, diagnostic and completion staging according to NLCSP QA and lung cancer CQIs[1] • Scanning (CT, U/S, mammography) and reporting capacity for additional findings • Nodule MDT preparation / attendance • Computer Aided Detection and Volumetry software • Interventional capacity (lung biopsy, lung markings, additional findings investigations) • FDG-PET capacity (& Nuclear Medicine reporting) • Sufficient administrative/IT support for sourcing, transferring and uploading prior imaging studies
Diagnostics	• EBUS (radial & linear) capacity (including theatres and anesthetics) • Lung function services (all new referrals) • Cardiopulmonary exercise testing • Pathology reporting workload (cytology, histopathology)
Thoracic Malignancy MDT	• Increased case numbers – implication on time and resources
Thoracic Surgery	• Increased outpatient demands • Increased theatre time (including anesthetics)
Medical Oncology	• Increased outpatient demands (~20-40% of cases will have advanced disease on baseline scan)[4 5 6] • Increased treatment (neo adjuvant, adjuvant)
Radiation Oncology	• Increased outpatient demands (~20-40% of cases will have advanced disease on baseline scan)[4 5 6] • Increased demand on SABR/SBRT • Increased demand on standard EBRT
Training Time	• For clinicians of all specialties to access and complete NLCSP training material • Specialist nurses and nurse navigators to learn new roles • Radiologists for implementation and use of new CAD/volumetry software • Staff to access/integrate with the National Cancer Screening Register (NCSR) and obtain participant data

Table 1. Summary of potentials impact of NLCSP on staffing and infrastructure

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4. The National Lung Sceening Trial Research Team. Reduced lung-cancer mortality with low-dose computed tomographic screening. New England Journal of Medicine. 2011; **365**: 395-409.
5. Tammemagi MC, *et al.* Participant selection for lung cancer screening by risk modelling (the Pan-Canadian Early Detection of Lung Cancer [PanCan] study): a single-arm, prospective study. The lancet oncology. 2017; **18**: 1523-31.
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