Peer Review

Aneurin Bevan Health Board

Lung Cancer Multidisciplinary Teams – Nevill Hall and Royal Gwent Hospitals

MEETING ATTENDANCE

Peer Review Team

Name (Print)	Job Title	Organisation
Gareth Collier	Consultant Physician	Hywel Dda Local Health Board
Ann Gostage	CNS	Betsi Cadwalader Health Board
Tom Crosby	Medical Director	South Wales Cancer Network
Glynis Tranter	Network Director	South Wales Cancer Network
Val Jones	Lay Reviewer	Healthcare Inspectorate Wales
Gareth Brydon	Review Lead	Healthcare Inspectorate Wales

Network Title	**South Wales Cancer Network**	
Organisation Title	**Aneurin Bevan Local Health Board**	
Team title	**Nevill Hall Lung Cancer Multidisciplinary Team**	
Review Date Title	**12/03/2013**	
Name (Print)	**Job Title**	**Organisation**
Matt Jones	Consultant Physician / MDT Lead Clinician	Aneurin Bevan Health Board
Andrew Morley	Consultant Radiologist	Aneurin Bevan Health Board
Mattheus Brouns	Consultant Physician	Aneurin Bevan Health Board
Mick Button	Consultant Oncologist	Velindre NHS Trust
Carol Davies	Cancer Nurse Specialist	Aneurin Bevan Health Board
Duncan Ingrams	Health Board Lead Clinician	Aneurin Bevan Health Board
Jane Hart	Lead Nurse	Aneurin Bevan Health Board
Nihal Kulatilake	Thoracic Surgeon	Cardiff & Vale Health Board

Meg Williams	Palliative Care Consultant	Aneurin Bevan Health Board
Doug Hymers	Cancer Services Manager	Aneurin Bevan Health Board
Helen Amos	MDT Co-ordinator	Aneurin Bevan Health Board

Network Title	**South Wales Cancer Network**	
Organisation Title	**Aneurin Bevan Local Health Board**	
Team title	**Royal Gwent Lung Cancer Multidisciplinary Team**	
Review Date Title	**12/03/2013**	
Name (Print)	**Job Title**	**Organisation**
Ian Williamson	Consultant Physician / MDT Lead Clinician	Aneurin Bevan Health Board
Alison Brewster	Consultant Oncologist	Velindre NHS Trust
Aliona Ionescu	Consultant Physician	Aneurin Bevan Health Board
Sam Williams	Clinical Nurse Specialist	Aneurin Bevan Health Board
Majid Rashid	Consultant Pathologist	Aneurin Bevan Health Board
David Jackson	Consultant Radiologist	Aneurin Bevan Health Board
Danya Jeffrey	Consultant Radiologist	Aneurin Bevan Health Board
Charlotte Ford	MDT Co-ordinator	Aneurin Bevan Health Board
Duncan Ingrams	Health Board Lead Clinician	Aneurin Bevan Health Board
Jane Hart	Lead Nurse	Aneurin Bevan Health Board
Nihal Kulatilake	Thoracic Surgeon	Cardiff & Vale Health Board
Doug Hymers	Cancer Services Manager	Aneurin Bevan Health Board

REVIEWERS REPORT

Key Themes

1 Structure and Function of the Service

The Peer Review Team would like to acknowledge the high level of commitment to the planning and organisation of the meeting held on 12/03/13. Within the Aneurin Bevan Health Board (ABHB) the 2 lung cancer multidisciplinary teams (MDTs) had fully engaged with the peer review process, supported by the Cancer Services Team.

Within the Aneurin Bevan Health Board (ABHB) there are 2 lung cancer multidisciplinary teams (MDTs) at Nevill Hall (NHH) and Royal Gwent (RGH) hospitals which had fully engaged with the peer review process, supported by the Cancer Services Team. Both teams functioned within well documented Operational Policies.

In the previous year the NHH team had managed 114 patients whilst the RGH team had managed 273 patients.

The two teams function separately and provide a comprehensive service on both sites. Selected patients with mesothelioma from NHH are referred to the mesothelioma MDT in Cardiff when a second opinion is deemed necessary whilst the pathway for patients in South Gwent was not so clear.

Both teams were well aware of their audit and performance data and had a very good knowledge of the patient pathway.

Both MDTs were not achieving compliance with the 62-day cancer waiting times targets. The Nevill Hall team recognised that they received a high level of Emergency Admissions, and are looking at ways to address this.

Access to PET is provided by PETIC and whilst the time taken to image and report varied this was generally a good service. There were issues however for some patients with access to EBUS services, provided by Cardifff and Vale Health Board. This service currently relies upon a single clinician and was therefore not a 52 week service.

Both teams provided what appeared to be an excellent pleural clinical service.

Oncology capacity at the Royal Gwent Medical Day Unit was raised as an issue. This could result in the delay of treatment for patients

The Royal Gwent MDT are not using the MDM Module within their MDT Meeting, as they do not have the facilities for dual projection whilst the NHH team supported the use of this facility.

Whilst in general the level of thoracic surgical support was inadequate, waits for cancer surgery did not appear to be an issue. It was noted that there are significant

issues with regards to surgical support for the MDT's.

2 Patient Centred Care and Experience

Both teams participated in the 2010 South East Wales Cancer Network 'Patients views of Lung Cancer Services In South East Wales' survey.

Overall the Patients were generally satisfied with the service/treatment they receive from the teams, but there seemed to be a low response with regards to the number of returned questionnaires.
Further surveys have been carried out, covering certain aspects of the service but there lacked a systematic approach to receiving patient feedback on the service received.

However, the Teams had looked recently at patient involvement in completing future questionnaires, and are looking to discuss this in more detail, as they need to repeat their survey and also involve Palliative Care in the process.

The Health Board has invested in Psychological services, but it was felt that the teams needed to ensure that there was clear awareness by the teams of the available assessment tools.
Whilst it was clear that the Health Board had access to 'stress thermometer' tools, it was not so clear that these were well known and used by the lung teams.

a. Evidence of Key worker

Both teams readily identified the lung CNS as the Key Worker and commended them on their level of patient support. Concerns were noted however about the 'lone-worker' where there were no cover arrangements for the Clinical Nurse Specialists within the Nevill Hall Team.

With support, the CNS could further develop their roles in terms of non medical prescribing, requesting of radiological investigations and nurse led follow up clinics.

3 Service Quality and Delivery

a. MDT Service Support

In general the teams were well supported with most members reporting they had dedicated time in their job plans for the MDT meetings.

Both MDTs highlighted the difficulties in fulfilling requirements of the National Cancer Standards in terms of Core Membership, in particular radiology, thoracic surgery and CNS at the Nevill Hall MDT, and oncology and thoracic surgery at the Royal Gwent MDT.

Whilst there was lack of Histopathologist presence at the Nevill Hall peer review meeting, and Palliative Care at the Royal Gwent Meeting, both teams asserted that levels of support and referral pathways were not an issue for these services.

There seemed to be a discrepancy in relation to Radiology input at the 2 meetings with a sole radiologist in NHH and cover available for the RGH team.

There are significant issues with regards to surgical support for the MDT's and the surgical resection rate for the Health Board is low.

The teams commented on a lack of cover for the core oncologists' leave provided by Velindre. There appeared little cross cover between the oncologists from both teams.

b. <u>Outcome Data</u>

Both teams demonstrated mature services with evidence of regular service review and development. The Nevill Hall team recognised that they received a high level of Emergency Admissions, and are looking at ways to address this across the LHB. Both teams demonstrated excellent engagement in clinical audit.

Collated responses For the Information Section of Peer review Key: X - No data provided	Met Target **ABHB - Nevill Hall**	**ABHB - Royal Gwent**	**National Target**	**Best LHB Wales**
Number of Non-small Cell Lung Cancer (NSCLC) patients having a resection.	8/59 (13.5%)	20/207 (10%)	14%	**HD- WGH 22%**
Number of USC referrals treated within 62 days.	106/131 (81%) Health Board Level		95%	**BCU- 98%**
Number of non-USC referrals treated within 31 days.	242/243 (99.6%) Health Board Level		98%	**BCU- YG, BCU YMW, C&V, HD-BGH, HD-GGH 100%**
Number of patient with pre-treatment stage recorded.	99.10%	97%	85%	**CT-RGH, HD- BGH, HD-GGH 100%**
Histological / cytological confirmation rate.	68%	74%	75%	**ABMU-NPT 83%**
Number of patients receiving active treatment for lung cancer.	59 (52%)	145 (53%)	60%	**HD-WGH 77%**
Number of small cell lung cancer patients receiving chemotherapy at any stage.	6/14 (43%)	24/41 (58%)	65%	**HD-BGH 100%**
Number of small cell lung cancer patients receiving treatment within 14 days of diagnosis.	7/ 14 (50%)	9/41 (22%)	100%	**ABMU - NPT 86%**
Number seen by specialist nurse at diagnosis.	100/114 (88%)	220/ 273 (80%)	100%	
Percentage of patients with 30 day post treatment mortality for:				
a) Chemotherapy;	0	1.40%		
b) Surgery.	0	0%		
Number of patients entered into clinical trials.	22/114 (19%)	19/273 (7%)	10%	
Number of patients donating tissue to the Wales Cancer Bank.	7	7	20% by 2016	

c. The following information was noted from the Wales Lung Cancer Data Report 2012

Above Welsh mean for CT Scan before Bronchoscopy for both hospitals.

Lower than Welsh mean for PET rate for Royal Gwent.

Below Welsh mean for SCLC patients receiving chemotherapy for Royal Gwent.

Below Welsh mean for SCLC patients receiving chemotherapy within 14 days for Royal Gwent.

Low rate of NSCLC Resections for both hospitals.

Low rate of chemotherapy for NSCLC for both hospitals.

All teams appeared aware of this information and reported that they were actively investigating the reasons for these variations.

d. Key audits projects and outcomes

Both teams have excellent data collection processes in place. The Nevill Hall Co-ordinator runs regular validation reports for the Lead Clinician. A number of in house audits have been undertaken by both MDT's and it would appear that key findings are addressed.

e. General Observations

Recording of pre-treatment stage and performance status was excellent across both teams.

The system for taking referrals and managing patients with SCLC meant that it was highly unlikely that even the majority of patients would be treated within the recommended time frame.

4 Review of Clinical Information in the Clinical Notes and Canisc

Review of the case notes using the Peer Review matrix provided evidence that a Key Worker had been allocated to the patient, information provided for the General Practitioner (GP) within the standard timescale, treatment/management plan, Co-morbidities and MDT discussion: the Key Worker was not recorded within Canisc.

5 Engagement with Management

It was recognised that ABHB Cancer Services are very engaged with adherence to National Cancer Standards and through engagement of the Executive Board have secured significant investment in Cancer Services across the Trust.

Generic issues relevant to the Lung Cancer MDT''s can be discussed at the Health Board Cancer Committee, which discussed issues on all Site Specific Cancers, but it was noted that it was more difficult to engage management in issues relating specifically to the Lung Cancer MDT and a separate forum should be considered for

this.

For example it was not clear what direct action had been taken by the Health Board management team with respect to the lack of thoracic surgical support for both MDTs.

6 Culture of the Teams

Both teams appeared mature in form and function. They have knowledgeable and well supported leads. The ABHB cancer service managers and clinical leads are clearly supportive of achieving excellence. They appear aware of information regarding their performance and outcomes and of key challenges and how these may be addressed. It would appear there is scope for closer working between the teams which would allow even greater alignment of treatment pathways and protocols and may allow some cross cover of key services.

GOOD PRACTICE Identify any areas of good practice
Good Practice/Significant Achievements: Excellent clinical leadership and support for members and disciplines of both MDTs. Excellent pleural and Thoracoscopy service across both sites. Good working partnership with Primary Care to address early awareness and early staging at presentation. Regular business / audit meetings are in place, which gives the teams time to reflect on progress and consider further developments required to improve the service. Excellent data collection, audit and awareness of the performance of both teams.
CONCERNS These should be brought to the attention of the team and a response from the LHB regarding its plans to remedy these concerns should be made
Lack of CNS cover at Nevill Hall. Lack of cover at The Nevill Hall MDT for Radiology, Thoracic Surgery and CNS**.** Lack of cover at the Royal Gwent MDT for Oncology and Thoracic Surgery. The clinical pathway for access to Oncology and treatment for patients with SCLC and NSCLC in RGH. Chemotherapy delivery capacity at the Royal Gwent Medical Day Unit.
Serious Concerns These should be brought to the attention of the team and a response from the LHB regarding its plans to remedy these concerns should be made.
None
Immediate Risks Identified? These should be brought to the attention of the team and a response from the LHB regarding its plans to remedy these concerns should be made within 1 week
None

Glossary: Lung Cancer Peer Review

ABHB	Aneurin Bevan Health Board.
Bronchoscopy	This is a technique of visualizing the inside of the airways for diagnostic and therapeutic purposes. An instrument (bronchoscope) is inserted into the airways, usually through the nose or mouth, or occasionally through a tracheostomy. This allows the practitioner to examine the patient's airways for abnormalities such as foreign bodies, bleeding, tumours, or inflammation. Specimens may be taken from inside the lungs. The construction of bronchoscopes ranges from rigid metal tubes with attached lighting devices to flexible optical fiber instruments with realtime video equipment.
Continuous Hyper Fractionated Accelerated Radiotherapy **(CHART)**	Hyperfractionated means giving more than one treatment (fraction) of radiotherapy per day. One type of hyperfractionated radiotherapy is called CHART. It stands for Continuous Hyperfractionated Accelerated Radiotherapy. The whole dose of radiation is about the same that would be applied for cancer with standard radiotherapy. The difference is that treatment is administered every day over 12 days instead of over several weeks. It requires a stay in hospital because as many as 3 treatments are administered every day.
CNS	Clinical Nurse Specialist.
Computerised Tomography	X-ray computed tomography, also computed tomography (CT scan) or computed axial tomography

(CT)	(CAT scan), is a medical imaging procedure that utilizes computer-processed X-rays to produce tomographic images or 'slices' of specific areas of the body. These cross-sectional images are used for diagnostic and therapeutic purposes in various medical disciplines.
CXR	Chest x-ray
DGH	District General Hospital.
Endobronchial Ultrasound **(EBUS)**	An endobronchial ultrasound (EBUS) is a procedure that may be performed during a bronchoscopy, to provide further information to diagnose or determine the stage of a lung cancer. This relatively new technique allows viewing of regions of the lungs and surrounding chest area that have traditionally required more invasive surgical procedures to evaluate.
GP	A General Practitioner.
HIW	Healthcare Inspectorate Wales.
Intensity Modulated Radiotherapy **(IMRT)**	This is an advanced mode of high-precision radiotherapy that uses computer-controlled linear accelerators to deliver precise radiation doses to a malignant tumour or specific areas within the tumour. IMRT allows for the radiation dose to conform more

	precisely to the three-dimensional (3-D) shape of the tumour by modulating—or controlling—the intensity of the radiation beam in multiple small volumes. IMRT also allows higher radiation doses to be focused to regions within the tumour while minimizing the dose to surrounding normal critical structures.
LHB	Local Health Board.
Multi Disciplinary Meeting **(MDM)**	A meeting made up of a variety of expert health care professionals.
Multi Disciplinary Team **(MDT)**	Multi-disciplinary teams (MDTs) are made up of expert health care professionals who have specialised knowledge and training in specific cancers. The teams meet regularly to discuss individual cases and to plan the best course of treatment for the patient. MDTs improve communication and decision making, waiting times and patient care.
Non Small Cell Lung Carcinoma **(NSCLC)**	NSCLC is any type of epithelial lung cancer other than small cell lung carcinoma (SCLC). As a class, NSCLCs are relatively insensitive to chemotherapy, compared to small cell carcinoma. When possible, they are primarily treated by surgical resection with curative intent, although chemotherapy is increasingly being used both pre-operatively (neoadjuvant chemotherapy) and post-operatively (adjuvant chemotherapy). The most common types of NSCLC are squamous cell carcinoma, large cell carcinoma, and adenocarcinoma, but there are several other types that occur less frequently, and all types can occur in unusual histologic

	variants and as mixed cell-type combinations.
Positron Emission Tomography **(PET)**	PET is a nuclear medical imaging technique that produces a three-dimensional image or picture of functional processes in the body. The system detects pairs of gamma rays emitted indirectly by a positron-emitting radionuclide (tracer), which is introduced into the body on a biologically active molecule. Three-dimensional images of tracer concentration within the body are then constructed by computer analysis. In modern scanners, three dimensional imaging is often accomplished with the aid of a CT X-ray scan performed on the patient during the same session, in the same machine.
Radiotherapy Treatment **(RT)**	Radiotherapy Treatment is the use of high energy x-rays and similar rays (such as electrons) to treat cancer.
Stereotactic Body Radiation Therapy **(SBRT)**	Stereotactic body radiation therapy (SBRT) is a technique that utilizes precisely targeted radiation to a tumour while minimizing radiation to adjacent normal tissue. This targeting allows treatment of small- or moderate-sized tumours in either a single or limited number of dose fractions.
VC	Video Conference facilities.