Peer Review

Abertawe Bro Morgannwg University Health Board

Lung Cancer Multidisciplinary Teams - Swansea, Neath Port Talbot & Princess of Wales

MEETING ATTENDANCE

Peer Review Team

Name (Print)	Job Title	Organisation
Ian Williamson	Consultant in Respiratory Medicine	Aneurin Bevan Health Board
Sue Davies	Primary Care Development Manager	South Wales Cancer Network
Jayne Emsley	Clinical Nurse Specialist	Betsi Cadwaladr University Health Board
Mansel Thomas	Lay Representative	Healthcare Inspectorate Wales
Glynis Tranter	Network Director	South Wales Cancer Network
Gareth Brydon	Review Lead	Healthcare Inspectorate Wales
Tom Crosby	Medical Director	South Wales Cancer Network

Network Title	**South Wales Cancer Network**	
Organisation Title	**Abertawe Bro Morgannwg University Health Board**	
Team title	**Princess of Wales Lung Cancer Multidisciplinary Team**	
Review Date Title	**06/03/2013**	
Name (Print)	**Job Title**	**Organisation**
François Lhôte	Consultant Thoracic Surgeon	ABMU
Martin Sevenoaks	Consultant Physician / MDT Lead	ABMU
Julie Parry	Lung Cancer CNS	ABMU
Jessica Pearce	MDT Co-ordinator	ABMU
Alex Harris	MDT Co-ordinator	ABMU
Sian Bleddyn	Consultant Radiologist	ABMU

Network Title	**South Wales Cancer Network**	
Organisation Title	**Abertawe Bro Morgannwg University Health Board**	
Team title	**Neath Port Talbot Lung Cancer Multidisciplinary Team**	
Review Date Title	**06/03/2013**	
Name (Print)	**Job Title**	**Organisation**
Martin Ebejer	Consultant Physician / MDT Lead	ABMU
Kath Rowley	Consultant Clinical Oncologist	ABMU
Angela Charles	Lung Cancer CNS	ABMU
Christine Woods	MDT Co-ordinator	ABMU
Ira Goldsmith	Consultant Thoracic Surgeon	ABMU
Marisa Bennett	Directorate Support Manager, Cancer Performance	ABMU
Melanie Simmons	Regional Services Performance Manager	ABMU
Network Title	**South Wales Cancer Network**	
Organisation Title	**Abertawe Bro Morgannwg University Health Board**	
Team title	**Swansea Lung Cancer Multidisciplinary Teams**	
Review Date Title	**06/03/2013**	
Name (Print)	**Job Title**	**Organisation**
Emrys Evans	Consultant Physician / MDT Lead	ABMU
Sharon Bennett	Macmillan Specialist Dietician	ABMU
Sarah Dawkins	Lung Cancer CNS	ABMU
Rhian Finn	Consultant Physician	ABMU
Elizabeth Birch	Consultant Palliative Medicine	ABMU
Karen Whitehouse	Lung Cancer CNS	ABMU
Sarah Price	MDT Co-ordinator	ABMU
Wendy Wilkinson	Macmillan APOT	ABMU
D E Roberts	Consultant Radiologist	ABMU

REVIEWERS REPORT

Key Themes

With reference to guidance on Key Themes in the evidence guides, please provide comments including details of strengths, areas for development and overall effectiveness of the team. Any specific issues of concern or good practice should also be noted in the following sections.

1. Structure and Function of the Service

The Peer Review Team undertook their review on 6th March 2013. The Abertawe Bro Morgannwg University Health Board (ABM UHB) three lung cancer multidisciplinary teams (MDTs) had fully engaged with the peer review process, supported by the Cancer Services Team.

Within ABM UHB there are three lung cancer MDTs based in Swansea, Neath Port Talbot and Bridgend. The Swansea team comprises both Singleton and Morriston Hospital clinicians with meetings held at the Morriston Hospital. The other MDT meetings are based at the Princess of Wales Hospital, Bridgend and the Neath Port Talbot Hospital, Baglan.

The number of patients managed by each of the MDTs in the previous year were:

Swansea 197, Neath-Port Talbot 86 and Princess of Wales 100.

There was evidence of extensive MDT service improvement. For example: the merger of two teams to form a single MDT across 2 hospital sites in Swansea, dedicated 'time-out' sessions for MDT development/audit, significant improvements in the provision of rehabilitation services pre and post treatment and use of the Canisc Multidisciplinary Teams Meeting Module. The Health Board has recently developed a MDT Operational Policy which provides a framework for MDT working and is currently in draft format.

The changes introduced as a result of the acute services reconfiguration within the Health Board has had a significant impact on the Swansea Lung Cancer team, seeing an increase in their activity as emergency admissions are now directed to Morriston & Singleton and Princess of Wales Hospitals, which in turn has had implications for the number of new patients discussed at the Neath Port Talbot Lung Cancer MDT, although the health board reported that subsequent management and follow up is arranged and undertaken locally.

A Multi-professional Lung Cancer website has been developed, which offers easy access to the lung cancer teams in ABM UHB. The website provides information on diagnosis, treatment and ongoing care as well as access to Macmillan patient information sheets and useful links to external websites and is an example of good practice that the Network would like to share with other Health Boards.

The Lung Cancer MDTs were not achieving compliance with the 62-day cancer waiting times targets and it was noted that reports on breaches are returned to the different specialty Directorates within the Health Board rather than the Lung Cancer MDTs themselves and therefore lacked ownership of the efficiency of the pathway.

Patients requiring EBUS, PET and EGFR testing have to be referred outside of the Health Board and there were variable delays in the undertaking and reporting of these investigations, which could contribute to delays in the pathway.

Pleural services are underdeveloped, with lack of ward based thoracic ultrasound at Neath Port Talbot and Swansea, and lack of medical thoracoscopy across the health board. There was consensus that improvement in this aspect of the pathway had the potential to reduce demand on the thoracic surgical services.

There was a lack of capacity in terms of inpatient beds/theatre time for thoracic surgery – it was noted that a service review was underway but it was not clear when the report of the review would be available. Despite this lack of resource, it was not apparent that the waiting time for cancer surgery was a significant contribution to treatment delays.

The MDT meeting facilities at Morriston Hospital were reported to be inadequate. Although there are apparently long-term plans associated with building developments to be commissioned during 2014, an interim solution is required.

Bi-annual business/audit meetings had been introduced for each of the teams across the Health Board, as an opportunity for a more co-ordinated approach to planning and development of their service. However the three teams did not meet together regularly to discuss patient pathways, treatment outcomes and further integration of services.

It was apparent that the diagnostic pathway within the Neath Port Talbot lung cancer MDT did not comply with NICE guidance, particularly with regard to undertaking bronchoscopy prior to CT Thorax.

Consistent presence of the clinical oncologist at MDT has resulted in an increase in chemotherapy rates as well as access to combined chemo/radiotherapy regimens. There is inequitable access compared to other areas in Wales to non-surgical oncology therapies, in particular more modern radiotherapy techniques such as CHART, IMRT and SBRT.

2. Patient Centred Care and Experience

There was no evidence of recent engagement with lung cancer patients to establish their views of the service. A Health Board wide patient satisfaction survey was undertaken in 2010, which included all tumour site specific cancers patients. There were very small numbers of lung cancer patients included in this survey and there were no recent updates. There were plans to canvass patient views for each of the tumour site specific cancers during 2013/14.

Patients were well supported with pre and post- rehabilitation services.

a. Evidence of Key worker

All MDTs reported the presence of a specialist nurse. However, there was not consistent support for the Key worker role and as a result some patients were not supported through their pathway.

3. Service Quality and Delivery

a. MDT Service Support

All three MDTs stated the difficulties in fulfilling requirements of the National Cancer Standards in terms of Core Membership, in particular:

- Swansea - No attendance of pathology at 46/46 MDT and no named cover, no attendance from palliative care at 18/46 MDT meetings and no cover
- Neath Port Talbot - no named pathologist and no cover, no attendance of pathology and palliative care at 49/49 MDT meetings, also no cover for Lung CNS
- Princess of Wales - No attendance from pathology at 15/50 MDT meetings and thoracic surgery at 13/50 meetings; also single handed CNS with no cover

b. Service Outcome Data

Collated responses For the Information Section of Peer review Key: X - No data provided	Met Target	ABMU - NPT	ABMU - POW	ABMU - Swansea	National Target	Best LHB Wales
Number of Non-small Cell Lung Cancer (NSCLC) patients having a resection.		9/57 (16%)	8/59 (13.5%)	6/109 (5.5%)	14%	**HD- WGH 22%**
Number of USC referrals treated within 62 days.		X			95%	**BCU- 98%**
Number of non-USC referrals treated within 31 days.		X			98%	**BCU- YG, BCU YMW, C&V, HD-BGH, HD-GGH 100%**
Number of patient with pre-treatment stage recorded.		85/86 (99%)	103/107 (96%)	195/197 (99%)	85%	**CT-RGH, HD-BGH, HD-GGH 100%**
Histological / cytological confirmation rate.		71/86 (83%)	71/107 (66%)	146/197 (74%)	75%	**ABMU-NPT 83%**
Number of patients receiving active treatment for lung cancer.		62/86 (72%)	69/107 (64%)	105/197 (53%)	60%	**HD-WGH 77%**
Number of small cell lung cancer patients receiving chemotherapy at any stage.		13/14 (93%)	6/12 (50%)	16/30 (53%)	65%	**HD-BGH 100%**
Number of small cell lung cancer patients receiving treatment within 14 days of diagnosis.		12/14 (86%)	6/ 12 (50%)	16/30 (53%)	100%	**ABMU - NPT 86%**
Number seen by specialist nurse at diagnosis.		94/101 (93%) Audit	94/107 (88%)	21/21 (100%) sample audit only	100%	
Percentage of patients with 30 day post treatment mortality for:						
a) Chemotherapy;		X	X	X		
b) Surgery.		0	0	0		
Number of patients entered into clinical trials.		15.7% Network Level			10%	
Number of patients donating tissue to the Wales Cancer Bank.		14.1% Network Level			20% by 2016	

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

Neath Port Talbot
Noted on WLCA high level of bronchoscopies before CT scans
Noted on WCLA high rate treatment NSCLC

Princess of Wales
Noted on WLCA high level of bronchoscopies before CT scans
Noted on WLCA low rate PET
Noted on WLCA low rate resection NSCLC
Noted on WLCA low rate chemotherapy NSCLC

Swansea MDT
No issues highlighted

d. General Observations

All three MDTs had designated lead clinicians who were well supported, but core membership varied across the three localities. Two of the three were small teams, with a lack of consistency in core membership and low activity levels. The recent reconfiguration of the acute emergency intake may have an impact on the viability of the Neath Port Talbot Lung Cancer Multidisciplinary team, given that national audits show that approximately 38% of lung cancers present as emergency admissions.

The Review Team expressed concern that the diagnostic pathway in Neath Port Talbot was not in keeping with NICE guidance and the practice of the other lung cancer teams within the Health Board, e.g. bronchoscopy prior to CT thorax. This was based on the evidence provided prior to the Peer Review visit and at the visit itself. The Neath Port Talbot team provide an excellent local out-patient service for their lung cancer patients. However the Review Team felt that the respiratory clinicians appeared to work in isolation from the other lung MDTs in ABMU and also considered that the MDT meetings were not fully functional. As a result of recent reconfiguration of emergency services, it was anticipated that the already relatively low number of new patients (86) discussed at this meeting could fall further. If this were to happen, the health board may wish to give serious consideration to reviewing the number of separate MDT meetings in the health board area.

There was a lack of engagement by the Histopathologist in the Peer Review Visit, there was no pathology input at all three review meetings.

All three MDTs highlighted the difficulties in fulfilling requirements of the National Cancer Standards in terms of Core Membership, in particular histopathology, with variable radiology, oncology, palliative care and thoracic surgery. All clinicians confirmed that the time allocated for the actual MDT meeting was included within the job plans. However, the radiologist highlighted difficulties in preparing for the meetings as this aspect of their role had not been built into their job plans. Preparation time for the MDT meeting is an essential part of radiology and pathology membership and should be recognised in the respective clinician's job plan.

4. Review of Clinical Information in the Clinical Notes and Canisc

Review of the case notes using the Peer Review matrix, also failed to provide

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 and MDT discussion: the Key Worker was not recorded within Canisc.

5. Engagement with Management

Management had strongly engaged with the Peer Review process. Some of the answers were however given on a corporate level rather than at the level of the MDT. The reporting of waiting times targets at a Cancer Services level rather than to the MDT was an example where greater ownership of the pathway and service could be taken by the MDTs themselves.

6. Culture of the Teams

Overall it was clear that there were many excellent and enthusiastic lung cancer specialists throughout the Health Board that provided strong clinical leadership. The recent merger of the 2 Swansea MDTs appeared to have been successful and there was a sense that the Peer Review process itself might have brought management closer to the service. It was apparent that there was much to be gained from looking further at service configuration, particularly with respect to the smaller MDTs, to ensure consistency of practice and service quality and delivery.

GOOD PRACTICE

Identify any areas of good practice

Good Practice/Significant Achievements:

- The bi-annual business/audit meetings provide the opportunity for MDT 'time-out' to reflect on progress and consider further developments required to improve the services
- The merger of the Singleton and Morriston teams to form a single MDT
- The 'pre-hab' and rehabilitation services
- The referral and pathway information existing on the LHB Intranet

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 cover for Clinical Nurse Specialists (Neath Port Talbot and Princess of Wales teams)
- Neath Port Talbot diagnostic pathway
- Radiology attendance at MDT and lack of radiology MDT prep time in clinicians job plan
- Facilities within the MDT meeting room in Morriston are inadequate
- Underdeveloped Pleural service, in particular no ward based thoracic ultrasound at Neath Port Talbot or Swansea and no access to medical thoracoscopy within any of the health board MDTs
- Access to and availability of EBUS – consider the development of this service within the health board
- Lack of adequate thoracic surgical service support

SERIOUS CONCERNS

These should be brought to the immediate attention of the team and a response from the LHB regarding its plans to remedy these concerns should be made

- Non-attendance of histopathologists at the Swansea and Neath Port Talbot Lung Cancer MDT Meetings
- The diagnostic pathway in Neath Port Talbot is not in keeping with NICE guidance. The review team felt, based on the evidence provided, that the Neath Port Talbot MDT did not practice as a fully functional MDT and there was a lack of routine access in the MDT meeting to all core disciplines particularly pathology and palliative care. The MDT also appeared to operate in isolation from other lung cancer MDTs in the Health Board. The recent reconfiguration of emergency services within the health board may further compromise the viability of this MDT. The Health Board may wish to give serious consideration to the sustainability of the current service configuration involving 3 separate MDT services.

Immediate Risks Identified

These should be brought to the attention of the team and a response from the LHB regarding it's plans to remedy these concerns should be made within 1 week

NONE

Glossary : Lung Cancer Peer Review

ABMU	Abertawe Bro Morgannwg University.
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 **(CT)**	X-ray computed tomography, also computed tomography (CT scan) or computed axial tomography (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	Radiotherapy Treatment is the use of high energy x-rays

Treatment **(RT)**	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.