Peer Review

Hywel Dda Health Board

Lung Cancer Multidisciplinary Teams – Bronglais, Glangwili & Withybush

MEETING ATTENDANCE

Peer Review Team

Name (Print)	Job Title	Organisation
Tom Crosby	Medical Director	South Wales Cancer Network
Jane Hart	Lead Nurse for Cancer	Aneurin Bevan Health Board
Ian Williamson	Consultant Respiratory Physician	Aneurin Bevan Health Board
Steve Evans	Telemedicine Service Support Manager	South Wales Cancer Network
Mansel Thomas	Lay Reviewer	Healthcare Inspectorate Wales
Niladri Ghosal	Consultant Clinical Oncologist	Betsi Cadwaladr University Health Board
Gareth Brydon	Review Lead	Healthcare Inspectorate Wales
Hywel Morgan	Network Director	South Wales Cancer Network

Network Title	**South Wales Cancer Network**	
Organisation Title	**Hywel Dda HB**	
Team title	**Bronglais MDT**	
Review Date Title	**13 March 2013**	
Name (Print)	**Job Title**	**Organisation**
Urfi Urfi	Consultant Respiratory Physician	Hywel Dda HB
Janette Arnold	Senior Cancer Coordinator	Hywel Dda HB
Sarah Davies	Lung Cancer CNS	Hywel Dda HB
Matthew Willis	Head of Cancer Services	Hywel Dda HB
Bob Bowen	Deputy Head of Cancer Services	Hywel Dda HB

Network Title	**South Wales Cancer Network**	
Organisation Title	**Hywel Dda HB**	
Team title	**Glangwili MDT**	
Review Date Title	**13 March 2013**	
Name (Print)	**Job Title**	**Organisation**
Gareth Collier	Consultant Respiratory Physician	Hywel Dda HB
Ira Goldsmith	Consultant Thoracic Surgeon	Abertawe Bro Morgannwg UHB
Kate Parker	Consultant Clinical Oncologist	Abertawe Bro Morgannwg UHB
Jayne Mainwaring	Cancer Services Coordinator	Hywel Dda HB
Sarah Morgan	Lung Cancer CNS	Hywel Dda HB
John Murphy	Consultant Pathologist	Hywel Dda HB
Melissa Birchall	Lung Cancer CNS	Hywel Dda HB
Fiona Daniels	Lung Cancer Support Worker	Hywel Dda HB
Matthew Willis	Head of Cancer Services	Hywel Dda HB
Bob Bowen	Deputy Head of Cancer Services	Hywel Dda HB

Network Title	**South Wales Cancer Network**	
Organisation Title	**Hywel Dda HB**	
Team title	**Withybush MDT**	
Review Date Title	**13 March 2013**	
Name (Print)	**Job Title**	**Organisation**
Tim Lewis	Consultant Respiratory Physician	Hywel Dda HB
Christine Paterson	Lung Cancer CNS	Hywel Dda HB
Sally-Ann Rolls	Research Nurse	Hywel Dda HB
Bob Bowen	Deputy Head of Cancer Services	Hywel Dda HB

Matthew Willis	Head of Cancer Services	Hywel Dda HB

REVIEWERS REPORT

Key Themes

1. Structure and Function of the Service

The Review Team met with representatives from all three lung cancer teams within Hywel Dda on the 13th March 2013.

The annual numbers of new cases discussed at the 3 MDTs are:

Glangwilli 171, Bronglais 38 and Withybush 92.

It was reported that there were 3 MDTs operating in Hywel Dda. Representation at each of the review meetings was however very variable, and in a number of cases core specialities, such as oncology, radiology, surgery at Withybush and radiology at all three teams, were not represented making it difficult to obtain information on all elements of the services under review.

Respiratory medicine services at Hywel Dda are provided on all 4 DGH Sites. The services at Prince Phillip Hospital, Llanelli and Glangwili Hospital, Carmarthen are provided by a single MDT based at Glangwili, with two consultant respiratory physicians. Out-patient services are provided on both sites. It became clear during the Peer Review visit that the service at Bronglais Hospital, Aberystwyth didn't function as a separate MDT and is 'de facto' part of the same multi-disciplinary meeting, although it was noted that there were differences in protocols and pathways followed by each unit. There is a single consultant based at Bronglais. The service at Withybush Hospital, Haverfordwest is a separate MDT supported by two consultant physicians.

The average length of time from date first seen to diagnosis varied considerably across the teams from 14 days at Bronglais to 22.5 days at Withybush. No team met the target for treating 95% of Urgent Suspected Cancers with 62 days. Average times to first treatment ranged from 27 days at Bronglais to 35 days at Withybush. All teams recognised the need to review their diagnostic and treatment pathways to see if speedier access can be achieved.

All MDTs reported that they had rapid access pathways in place. The system of copying the chest physician into all abnormal CXR or CT reports at Withybush was noted by the review team. Here, all suspicious chest x-rays and scans, requested both by GPs and from other specialties within the hospital are 'flagged up' to the Chest physicians. They then check that a referral is received, 'chasing up' the referrer where necessary. The one-stop diagnostic service and pre-clinic meeting at Glangwili & Llanelli, to plan and expedite the diagnostic pathway and minimise delays, was also noted. This is preceded by a clinical meeting at which the diagnostic pathway for each patient is agreed, to minimise delays through the

pathway.

Access to pathology was noted to be a challenge across all cancer services, but note was made to rationalise this support through efficient working practices. All the teams recognised that Pathology turnaround times were too long. The review team noted the development of a strong health board wide EBUS service at Glangwili, and all teams reported good and timely access to the service, the turnaround time for EBUS was now only two days.

Thoracic surgery is provided by ABMU at Morriston Hospital. There is inadequate support for all MDTs, especially with regard to cover, but it did not appear that this contributed to delays in the clinical pathway.

Oncology services are provided by clinical and medical oncologists from both Hywel Dda and Abertawe Bro Morgannwg University (ABMU) Health Boards.

Particular note was made throughout the Peer Review visit of the challenges to provide services and patient support in a Health Board that is very rural in places. Whilst there were examples of excellent practice being developed by CNSs which could be shared by others in Wales it was important that these developments took place within the context of wider professional support and that efforts were made to benchmark activity with other similar parts of Wales or indeed the UK.

2. Patient Centred Care and Experience

There was no evidence of recent surveys with lung cancer patients to gain their views of the service. A network-wide lung cancer patient satisfy action survey was undertaken in 2009, and a survey to gain feedback after the introduction of the one-stop clinics in Carmarthenshire in 2010. The Glangwili Team stated that they wanted to get more feedback from patients but were constrained by lack of staff resources.

All MDTs had strong and motivated Clinical Nurse Specialists, providing a high level of support for patients, but cover was identified as an issue particularly in Withybush and Bronglais. All MDTs were developing holistic needs assessments for their patients.

Services were being developed to suit the rural nature of the health board, including local nurse led clinics in Carmarthenshire and a community based CNS offering support at home from Bronglais. Not all the CNS's were independent prescribers, which limited the range of support, and care they could provide.

a) Evidence of Key worker

All teams reported that the CNS was the identified Key Worker, though this wasn't always indicated clearly in the clinical notes.

3. Service Quality and Delivery

a. MDT Service Support

There was evidence of extensive service improvement including the development of a single service across Carmarthenshire.

Thoracic surgery is provided by ABMU at Morriston Hospital. There is inadequate support for all MDTs, especially with regard to cover. The thoracic surgeon video-conferences (VC) into the meetings, but for a very limited amount of time at Withybush (10 minutes), because of the need for the surgeon to video-conference with the Carmarthenshire Lung MDT at Swansea. This has led to the need to pre-select cases for discussion with the thoracic surgeon, which is not considered best practice.

Oncology services are provided by clinical and medical oncologists from both Hywel Dda and Abertawe Bro Morgannwg University (ABMU) Health Boards. There are problems with regard to cover for all MDTs. The Review Team also noted that there was currently no access to specialist radiotherapy services such as CHART, IMRT and SBRT.

There appeared to be variation in the level of MDT co-ordinator support to the teams. The Glangwili and Bronglais co-ordinators played a strong and supportive role in their MDTs. However there had been limited MDT support for the Withybush team and the team reported that it had affected the recent collection of patient data to support patient management and for the national audits.

It was clear that there were problems with input from a number of core specialists into all the MDTs. Radiology support to all MDTs was inadequate, including a lack of cover. This was particularly so at Withybush where the chest physician reported having to stage CTs in the MDT meeting and having limited access to interventional radiology.

There were also difficulties in ensuring adequate support from pathology, although there had been recent improvements in the Glangwili MDM. There is no pathology attendance at the Withybush MDT. There are also delays in pathology turnaround times. It was recognised that there are plans to improve pathology services across the health board.

b. Service Outcome Data

Collated responses For the Information Section of Peer review Key: X - No data provided	Met Target **Bronglais**	**Withybush**	**Glangwili/Princ e Phillip**	**National Target**	**Best LHB Wales**
Number of Non-small Cell Lung Cancer (NSCLC) patients having a resection.	3 (16.5%)	11/49 (22%)	16/117 (13.6%)	14%	HD- WGH 22%
Number of USC referrals treated within 62 days.	27 (70%)	19 (89%)	70 (76%)	95%	BCU- 98%
Number of non-USC referrals treated within 31 days.	38 (100%)	63 (100%)	86 (99%)	98%	BCU- YG, BCU YMW, C&V, HD-BGH, HD-GGH 100%
Number of patient with pre-treatment stage recorded.	38/38 (100%)	83/92 (90%)	171/171 (100%)	85%	CT-RGH, HD- BGH, HD-GGH 100%
Histological / cytological confirmation rate.	82%	67/92 (73%)	134/171 (78%)	75%	ABMU-NPT 83%
Number of patients receiving active treatment for lung cancer.	63%	71 /92 (77%)	115/171 (67%)	60%	HD-WGH 77%
Number of small cell lung cancer patients receiving chemotherapy at any stage.	100%	10/15 (67%)	9/14 (64%)	65%	HD-BGH 100%
Number of small cell lung cancer patients receiving treatment within 14 days of diagnosis.	2/4 (50%)	5/15 (33%)	X		ABMU - NPT 86%
Number seen by specialist nurse at diagnosis.	0	18/92 (19%)	X	100%	
Percentage of patients with 30 day post treatment mortality for:					
a) Chemotherapy;	0	0	X		
b) Surgery.	0	0	X		

Number of patients entered into clinical trials.	5/38 (13%)	12/ 92 (13%)	0	10%	
Number of patients donating tissue to the Wales Cancer Bank.	0	0	0	20% by 2016	

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

% of all lung cancer patients having a CT scan before bronchoscopy below Welsh average at Withybush.

PET rate lower than the Welsh Mean in all hospitals.

Very low percentage of lung cancer patients seen by a CNS at Bronglais (It was noted that a CNS had now been appointed).

Active treatment rates for NSCLC at Glangwili and Prince Philip Hospitals were significantly lower than the Wales mean.

% of patients with histologically confirmed NSCLC who received a PET Scan was significantly below the Welsh average at Glangwili Hospital.

Resection rates for NSCLC at all hospitals were significantly below the mean reported. All teams were aware of this information and reported that they were actively investigating the reasons for these variations.

a. Key audits projects and outcomes

All teams participated in the National Lung Cancer Audit. Evidence of local audits was provided for Glangwili and Bronglais, but details of outcomes were not available. Both these teams reported having undertaken recent audits of their patient pathways, and the Carmarthenshire data had been presented at a Network Lung Cancer Workshop.

b. General Observations

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

The Review team expressed significant concern at the apparent lack of an appropriate out-of hours service / helpline for Withybush patients with chemotherapy related toxicity and felt that this constituted an immediate risk to patients. The Review Team were unable to ascertain the full extent of the issue elsewhere in Hywel Dda at the Review meeting.

There are low access rates to radiotherapy at Bronglais, although the MDT representatives assured them that all radical patients are fully considered for RT. Whilst the Review Team acknowledged the large distances patients had to travel for radiotherapy and that this may affect patient choice, it was important to ensure that optimum care was not adversely influenced by the geography of the area. It was noted that there were other similar communities in the UK against which they could benchmark.

One of the Swansea based oncologists reported that she participated in the Singleton process for reviewing morbidity and mortality and serious clinical incidents. There did not appear to be a common system for the investigation of such issues across the Health Board

There was progress in increasing access to high quality clinical trials at all hospitals, and there was trials nurse support available to the MDTs. The Review Team noted the attendance of the Trials Nurse at the Withybush review meeting.

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

Review of the case notes using the Peer Review matrix provided evidence that:

- the Key Worker was not routinely recorded in the Notes or on Canisc for any of the three teams.
- information was provided to the General Practitioner within the standard timescale, for Bronglais and Glangwili (Canisc evidence) but not at Withybush
- FEV1 was clearly recorded as were co-morbidities, Care Plans and that there was an agreed Cancer Management Plan and MDT discussion.

6. Engagement with Management

Some MDT members mentioned a lack of executive support for cancer services and a lack of involvement by the MDTs in the development of the Health Board plans for cancer services in Hywel Dda.

The Review Team were also informed that issues regarding the lack of adequate Pathology & Radiology support for the Teams had been raised with the Health Board management on a number of occasions, but that the problems remained unresolved.

Management representation at the Review stated they were aware of these issues.

7. Culture of the Teams

In general it was noted that significant progress had been made by the clinical lead for lung cancer services in Hywel Dda in recent years. He is a strong clinical lead, has the support of his colleagues and has a strong vision for future developments of lung cancer services within the LHB and Wales. He probably underestimates the progress he has already made!

The Review team was made aware of potential differences of opinion between some core members of the Withybush MDT relating to the oncology management of patients. As not all core members were present at the Peer Review meeting it was not possible to explore this in any further detail. Other members of the MDT felt that access to oncology services was not compromised, but rather that there was a clash of personalities within the team. Nevertheless, the strength of the criticism was of concern to the Peer Review Team.

GOOD PRACTICE

Identify any areas of good practice

Good Practice/Significant Achievements:

- Strong Clinical Nurse Specialist support appropriate to geography of the Health Board – including the Community based CNS at Bronglais and the developing community based nurse-led clinics in Carmarthenshire
- Development of combined Glangwili & Prince Phillip service with one stop clinic
- Flagging of Abnormal Chest X-rays and CT to Chest physicians at Withybush
- Pre-Diagnostic Clinic Meeting at Glangwili to manage diagnostic pathway
- The establishment of an EBUS service at Glangwili, serving all the Health Board.

CONCERNS

Refer to the guidance on identifying concerns. Any immediate risks or serious concerns must be brought directly to the attention of the core team

- Inadequate radiology support for all MDTs
- Inadequate pathology support and pathology turnaround times for all MDTs
- Inadequate surgical input to all teams, particularly cover
- Low uptake of radiotherapy treatment at Bronglais
- Relationships between one of the respiratory physicians and the oncologist in the Withybush MDT.

SERIOUS CONCERNS

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

- Lack of radiology support for Withybush MDT resulting in a chest physician staging CTs in the MDT meeting.
- Lack of access to interventional radiology at Withybush.

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

- The lack of an appropriate out-of hours service / helpline for Withybush chemotherapy. Patients, including those with possible neutropenic sepsis, are advised to attend A&E if they feel unwell. The review Team did not ascertain the full extent of the issue elsewhere in Hywel Dda at the Review visit.

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.
CHART (Continuous Hyper Fractionated Accelerated Radiotherapy)	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.
CT (Computerised Tomography)	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.
EBUS (Endobronchial Ultrasound)	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.
IMRT (Intensity Modulated Radiotherapy)	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.
MDM (Multi Disciplinary Meeting)	A meeting made up of a variety of expert health care professionals.
MDT (Multi Disciplinary Team)	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.
NSCLC	NSCLC is any type of epithelial lung cancer other than

(Non Small Cell Lung Carcinoma)	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.
PET (Positron Emission Tomography)	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.
RT (Radiotherapy Treatment)	Radiotherapy Treatment is the use of high energy x-rays and similar rays (such as electrons) to treat cancer.
SBRT (Stereotactic Body Radiation Therapy)	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.