

# Lung Cancer 2013 Peer Review All Wales Report

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# Lung Cancer Peer Review 2013

## All Wales Summary Report

### Cancer NSAG Lung Group

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#### Introduction to peer review

Peer review of cancer services in Wales is a quality assurance programme of the services delivered, by multi-disciplinary teams (MDTs) and health boards (HBs) against a framework of standards of care. It takes account of the findings of clinical audits, engagement with the patient pathway and patient experience. The findings are to support Welsh Government, commissioners, NHS managers, clinical teams, the third sector, patients, carers and the public in understanding where the delivery of cancer care is of high quality and where service improvements are required.

It combines self assessment with independent expert review to not only ensure structures and processes are in place to deliver high quality care, but that clinical teams are working effectively together. Integral to this is an expectation of continuous improvement in treatment outcomes and patient experience.

In Wales peer review of cancer services, which began in 2012, is based on the requirements of the National Cancer Standards and is delivered by the Cancer Networks in partnership with Health Inspectorate Wales (HIW). The aim has been for the programme to be led by clinical experts, underpinned by a rigorous governance structure, assuring NHS Wales and the public that services are safe, of high quality, responsive to patient and carer needs, and to encourage clinical ownership of both the current service quality and the systems to provide continuous service. The evidence considered by the peer review team came from both face to face interviews and data on clinical pathways and processes<sup>1</sup>. At the time of this first peer review of lung cancer services, there were fourteen lung cancer MDTs in Wales and all participated in the process.

#### Key findings

The key findings highlighted in this all Wales summary have been collated from each HB's Peer Review final report issued by the Peer Review Team. Each HB has produced an action plan to address the points raised at peer review. These HB reports and action plans should be referred to if further detail, not presented here, is of interest. HIW has agreed to host these reports in order to support the open and transparent reporting of conclusions. A public version of the report and the action plan is, therefore, published on HIW's website. It is also expected that this information is also publically available on Health Board websites.

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<sup>1</sup>Data submitted was for 2011

It is important to note that the key findings from each peer review visit and presented below relate to the outcomes of discussions on the day based on data collated for the calendar year 2011. They may not reflect current services now being provided. This is in keeping with all peer review methodologies. Acronyms used for LHBs are summarised in Appendix 1.

### **Good practice**

All HBs were recognised as having good practices. Strong clinical leadership was evidenced in all HBs and nearly all constituent MDTs resulting in development of staff roles, efficient use of resources and ring fenced time to review and develop services based on clinical audit findings.

Specific examples were:

- clinical nurse specialists leading follow up and breathlessness clinics (C&VUHB); support for community based services in rural areas which provided more accessible services for patients (HDHB)
- engagement with primary care (ABHB) and development of an e-learning module to increase knowledge of primary care staff (C&VUHB)
- rapid access clinics (CTHB) and early warning system in radiology to speed up the diagnostic process for patients (HDHB).
- HB-wide endobronchial ultrasound and pleural and thoracoscopy services to improve the diagnostic process (BCUHB)

Clinical audit findings provide the best means for lung cancer MDTs to confidently benchmark their services with others in Wales, the UK and internationally. This round of peer review benefited from excellent clinical audit data. The ability for each MDT to have time, in addition to their clinical team meeting, to reflect on their performance as detailed in annual audit reports is very important. It supports leadership and a culture of on-going quality improvements aiming to provide care that fully supports the patient through the cancer pathway and reflects best practice.

### **Benchmarking performance**

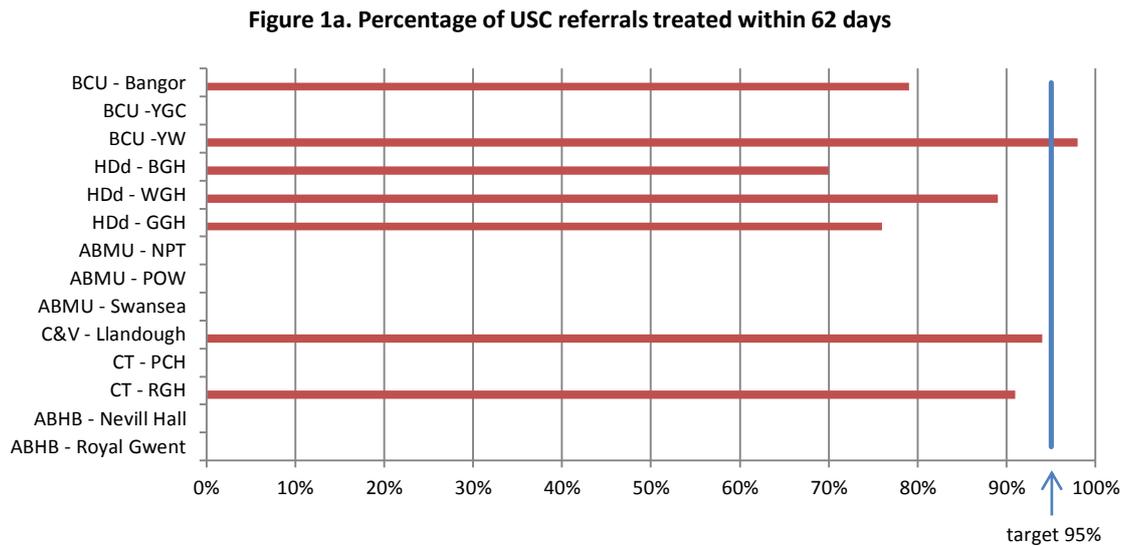
The following clinical and process indicators have been selected to provide an overview and are associated with the main stages in the clinical pathway from referral to treatment.

#### **1) Waiting times**

Delays to start of definitive treatment are of concern as they can exacerbate anxiety for patients and their carers' and may impact on the effectiveness of care provided.

**a. Urgent Suspected Cancer (USC) referrals starting treatment within 62 days (target 95%)**

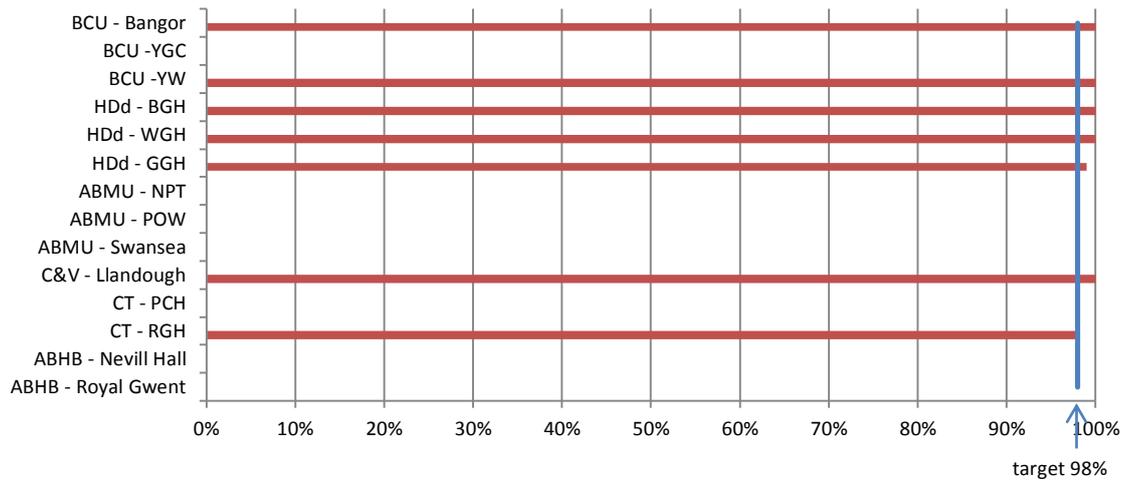
Time to start of definitive treatment for patients referred by their GP with suspected cancer, by MDT, was challenging with wide variation across the seven MDTs that submitted data from 70% to 98% with a mean of 85% (Figure 1a). ABHB reported performance at the HB (81%) rather than MDT level, data submitted by BCU-YGC and CT-PCH could not be analysed and no data were submitted for MDTs in ABMU.



**b. Non USC referrals starting treatment within with 31 days (target 98%)**

For patients not referred with suspected cancer by their GP, all of the seven MDTs that submitted data achieved high levels of performance either meeting or exceeding the target (Figure 1b). Again, ABHB reported performance at the HB (99.6%) rather than MDT level, data submitted by BCU-YGC and CT-PCH could not be analysed and no data were submitted for MDTs in ABMU.

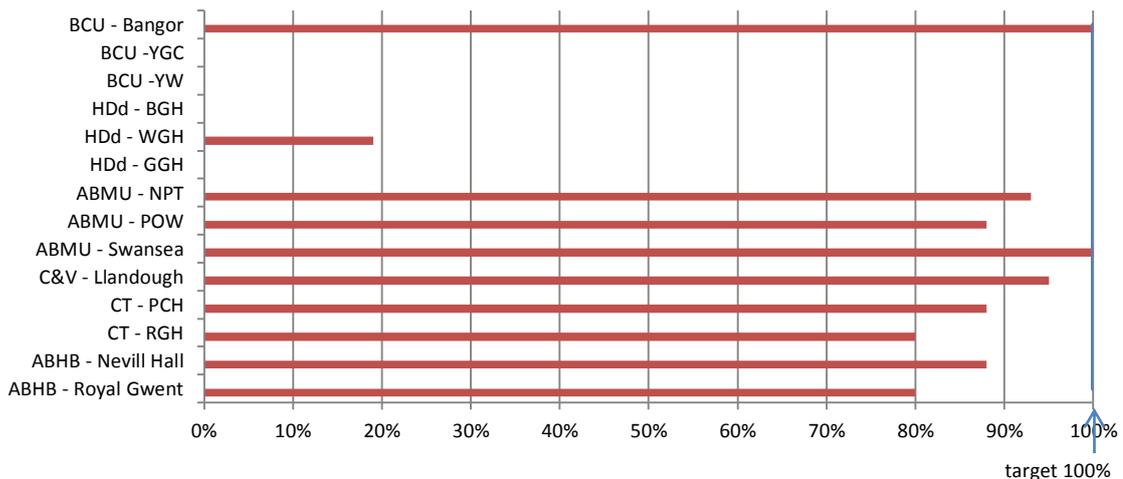
**Figure 1b. Percentage of non-USC referrals treated within 31 days**



**2) Patients seen by specialist nurse at diagnosis (target 100%)**

Access to a clinical nurse specialist, often the patient’s Key Worker, is a very important quality measure for patients<sup>2</sup>. On average, for those MDTs submitting data, just over three quarters of their patients were seen by a specialist nurse. Two of the ten MDTs that submitted data achieved the target for all their patients with a further two in excess of 90% (Figure 2). For those HBs with no data shown, HDd-BGH MDT did not have a clinical nurse specialist at the time of the peer review but has now addressed this. Three other MDTs, HDd-GGH, BCU-YGC and BCU-YW, did not provide data.

**Figure 2. Percentage of patients seen by specialist nurse at diagnosis**

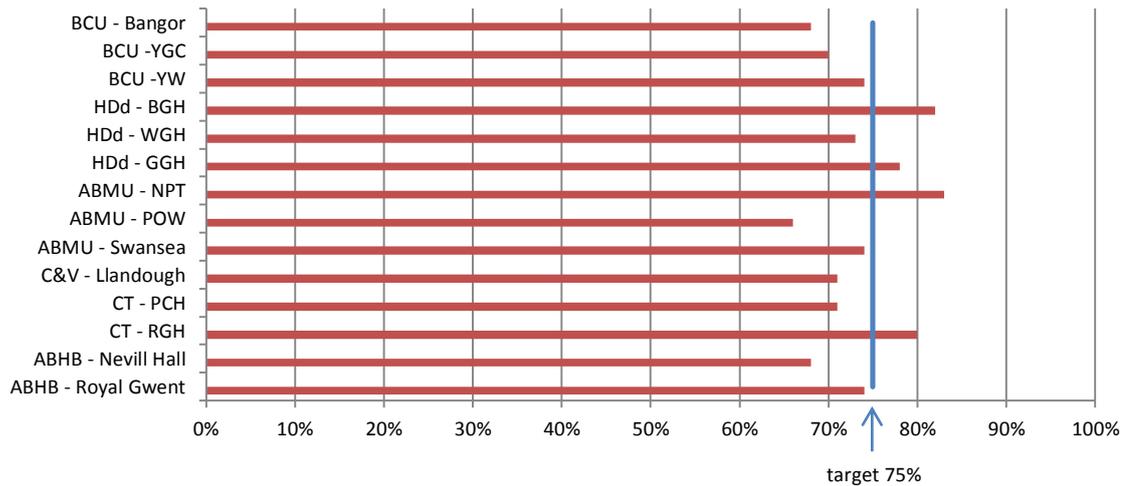


<sup>2</sup> Wales Cancer Patient Experience Survey, 2013  
<http://wales.gov.uk/topics/health/publications/health/reports/report13/?skip=1&lang=en>

### 3) Histological/cytological confirmation rate (target 75%)

Histological diagnosis is increasingly important as research continues to identify subtypes of lung cancer based on molecular markers. Figure 3 shows the variation across all fourteen MDTs for this indicator ranging from 66% to 83% with the mean just below the target at 73.7%. Four MDTs reached and exceeded the target.

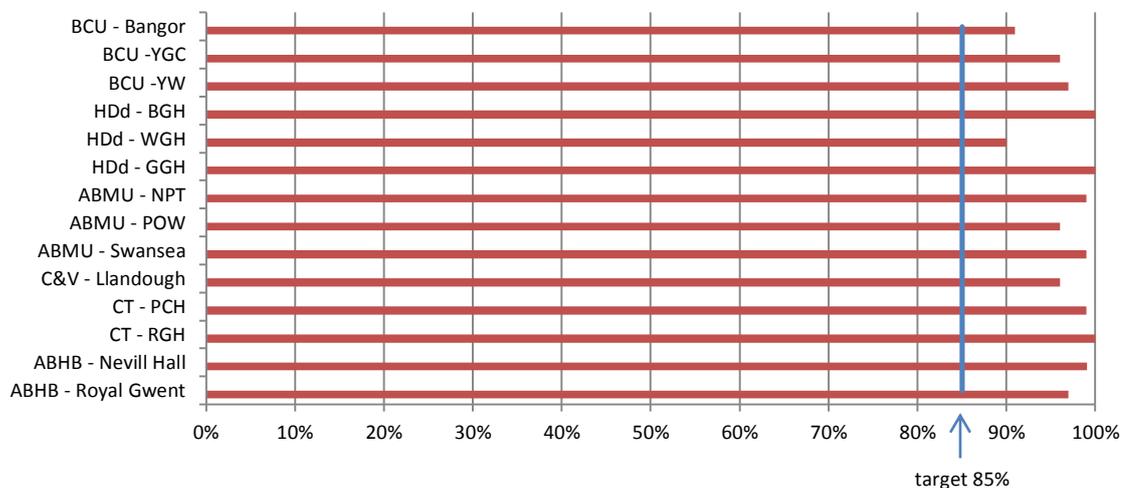
Figure 3. Percentage of histological/cytological confirmation rate



### 4) Patients with pre-treatment stage recorded (target 85%)

This target is important because accurate staging is crucial for making treatment choices and giving information on prognosis. Information on stage distribution may provide evidence of success in efforts to diagnose cancers earlier in their course. All MDTs exceeded the target for recording pre-treatment stage with all exceeding 90% and three achieving 100% (Figure 4). This level of achievement is excellent and should provide the challenge for HBs to aim for similar performance across all their cancer MDTs.

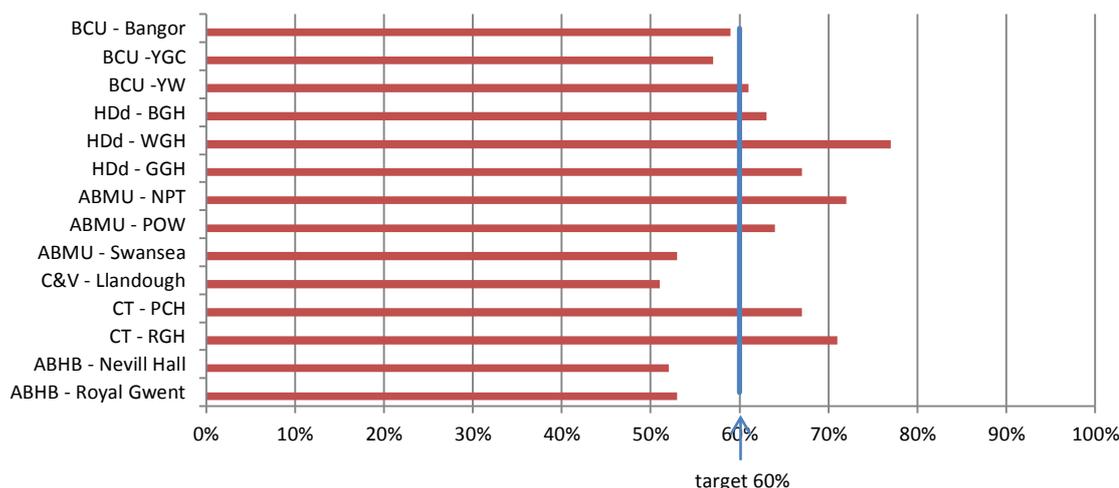
Figure 4. Percentage of patients with pre-treatment stage recorded



## 5) Patients receiving active treatment (target 60%)

This measure relates to surgical resection, radiotherapy and chemotherapy. There was wide variation across fourteen MDTs ranging from 51% to 77% with the mean at 62% (Figure 5). Eight MDTs exceeded the 60% target.

Figure 5. Percentage of patients receiving active treatment



## 6) Patients with non small cell lung cancer (NSCLC) having a resection (target 14%)

Surgery is the treatment of choice offering the best chance of cure for patients with good performance status and early stage NSCLC. Only five of fourteen MDTs reached or exceeded the target of 14%, with a further four MDTs within 0.5% (Figure 6). It is important to set this current target in the wider context as the overall resection rate in 2012 for both England and Wales, grouped together, and Scotland was just over 20%<sup>3</sup>. This level of resection is considered low and a contributory factor associated with poor survival of patients with lung cancer in the UK compared to that observed in other European countries<sup>4</sup>. This has been a concern of the Cancer NSAG Lung Group for a number of years.

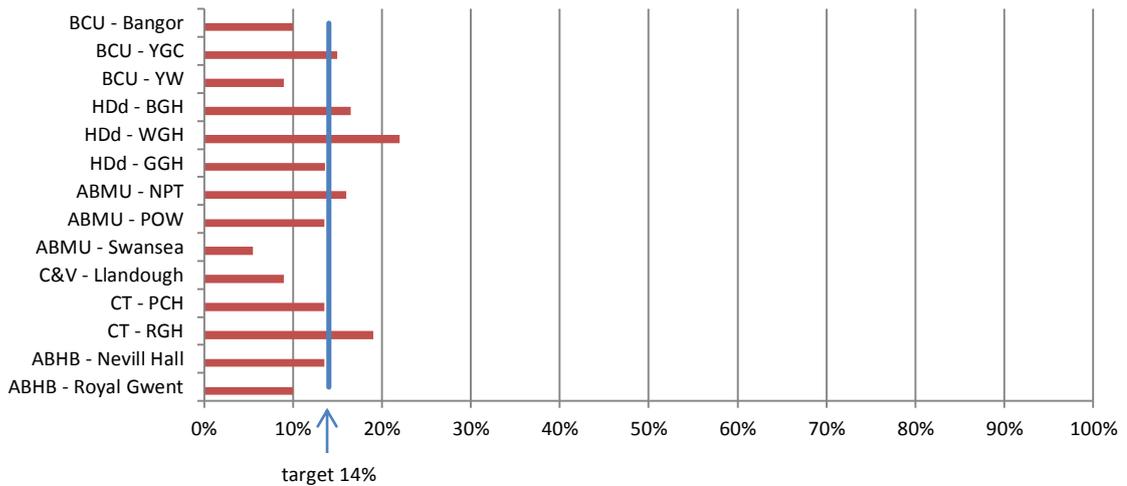
<sup>3</sup> National Lung Cancer Audit Report 2013. Report for the audit period 2012

<sup>4</sup> Cancer survival in Europe 1999-2007 by country and age: results

of EUROCARE-5-a population-based study. De Angelis R.; Sant M.; Coleman M.P. *et al. The Lancet*, 377,9760,127-138

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)62231-3/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)62231-3/fulltext)

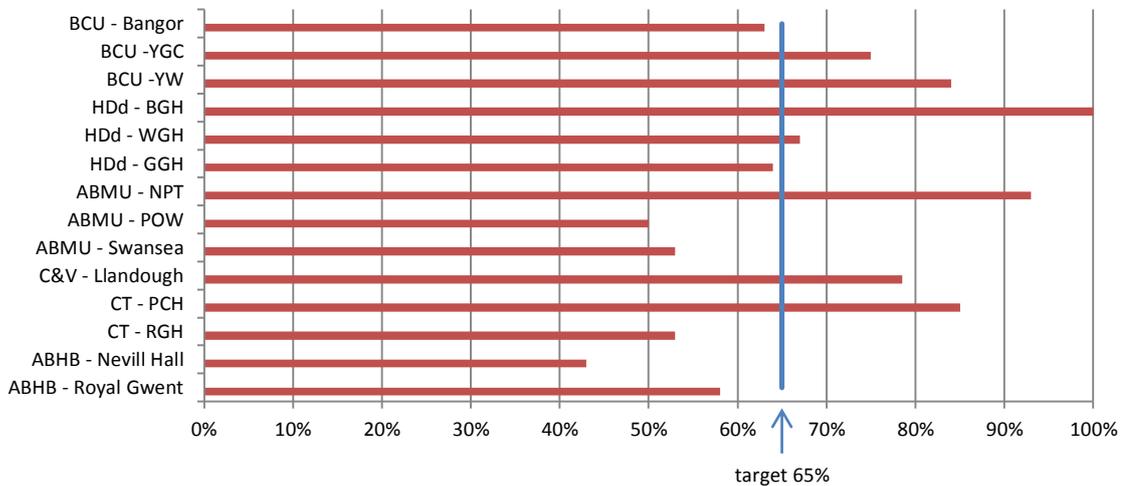
**Figure 6. Percentage of patients with NSCLC having a resection**



**7) Patients with small cell lung cancer (SCLC) receiving chemotherapy at any stage (target 65%)**

Chemotherapy, used alone or in combination with radiotherapy, is the preferred treatment for SCLC. Performance varied widely across MDTs and between MDTs within an HB ranging from 43% to 100% with the mean at 69% exceeding the target (Figure 7).

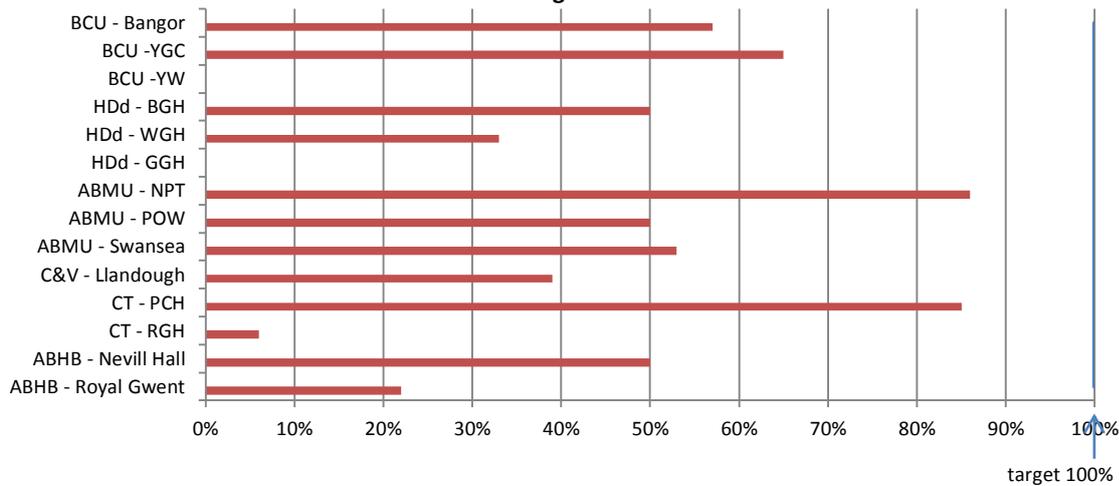
**Figure 7. Percentage of patients with SCLC receiving chemotherapy at any stage**



**8) Patients with SCLC receiving treatment within 14 days of diagnosis (target 100%)**

This is important for patients with SCLC as the disease can progress quickly and, where this happens, may limit the treatment options available. None of the MDTs that submitted data achieved the target. The mean was 50% with wide variation in performance from 6% to 86% both between HBs and between MDTs in the same HB (Figure 8). Data from BCU-YM could not be analysed and no data were submitted from HDd-GGH.

**Figure 8. Percentage of patients with SCLC receiving treatment within 14 days of diagnosis**



### Concerns identified and next steps

Peer review considers three categories of risk, namely concerns, serious concerns and immediate risks. These are defined in Appendix 2. Whilst all six HBs were noted as having a number of concerns identified, only three were identified as having serious concerns (HDHB, C&VUHB and ABMUHB) and one with an immediate risk (HDHB).

A consistent concern across all HBs was the varying ability to adequately support MDTs with input from all specialties<sup>5</sup> at the regular MDT meeting where diagnostic and staging information is reviewed and patient management options considered. Lack of surgical input to the MDT meeting was reported by five of the six HBs. This may be making a significant contribution to low resection rates for non small cell lung cancer. In addition, MDT meetings with inconsistent or no input from radiology, pathology, oncology and a CNS were noted less often but are as important to address for those MDTs concerned. Linked to this was little formal recognition in job plans of time commitment required to attend the MDT meetings.

Whilst HBs will already be working to implement their action plans it is important to emphasise those improvements that are required across all lung cancer MDTs. This peer review process has highlighted areas where prompt action is necessary. There are four specific areas that the Lung Cancer NSAG view as priorities to improve outcomes for patients.

<sup>5</sup> See National Cancer Standards for Lung Cancer [http://www.wales.nhs.uk/sites3/documents/322/National\\_Standards\\_for\\_Lung\\_Cancer\\_Services\\_2005\\_English.pdf](http://www.wales.nhs.uk/sites3/documents/322/National_Standards_for_Lung_Cancer_Services_2005_English.pdf)

1. In line with the National Cancer Standards, HBs should review the number of MDTs they support to ensure that in future specialist lung cancer MDTs are adequately resourced with appropriate cover to fully function throughout the year. Care pathways need to reflect best practice as endorsed by NICE guidance and guidelines.
2. MDTs with low histological confirmation rates should review their pathways and identify any underlying reasons contributing to this finding.
3. Low resection rates for NSCLC should be addressed as a matter of urgency and will require an increase in the provision of thoracic surgical services within South Wales. This is being addressed by the Welsh Health Specialist Services Committee but needs to be resolved as a matter of urgency with progress monitored via the HB annual peer review action plan process.
4. All MDTs in Wales should review their pathway to commence chemotherapy within two weeks for patients diagnosed with small cell lung cancer.

## Appendix 1

### HB acronyms

<b>Health Board</b>	<b>Hospital</b>	<b>Acronym</b>
Betsi Cadwaladr University Health Board	Ysbyty Gwynedd	BCU - Bangor
	Glan Clwyd Hospital	BCU - YGC
	Wrexham Maelor Hospital	BCU - YW
Hywel Dda University Health Board	Bronglais General Hospital	HDd - BGH
	Withybush General Hospital	HDd – WGH
	Glangwili General Hospital	HDd - GGH
Abertawe Bro Morgannwg University Health Board	Neath Port Talbot Hospital	ABMU – NPT
	Princess of Wales Hospital	ABMU - POW
	Swansea	ABMU - Swansea
Cardiff & Vale University Health Board	University Hospital Llandough	C&V - Llandough
Cwm Taf University Health Board	Prince Charles Hospital	CT - PCH
	Royal Glamorgan Hospital	CT - RGH
Aneurin Bevan University Health Board	Nevill Hall Hospital	ABHB - Nevill Hall
	Royal Gwent Hospital	ABHB - Royal Gwent

## Appendix 2

### Definitions of Concerns

The lowest level of risk is referred to as a **concern**. This is an issue that affects the delivery or quality of the service that does not require immediate action but can be addressed through the work programme of teams/services.

A **serious concern** is an issue that, whilst not presenting an immediate risk to the patient or staff safety, could seriously compromise the quality or clinical outcomes of patient care, and therefore requires urgent action to resolve.

Finally, an **immediate risk** is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action.