Urological Cancers Peer Review 2014

Abertawe Bro Morgannwg University Health Board

Morriston, Princess of Wales and Neath Port Talbot Hospitals

MEETING ATTENDANCE

Peer Review Team

Name	Job Title	Organisation
Tom Crosby	Medical Director	South Wales Cancer Network
Adam Carter	Consultant Urologist	Aneurin Bevan University Health Board
Jim Barber	Consultant Clinical Oncologist	Velindre NHS Trust
Jane Hart	Cancer Lead Nurse	Aneurin Bevan University Health Board
Maggie Lucas	Lead Cancer Manager	Cardiff & Vale University Health Board
Mansel Thomas	Lay Reviewer	Healthcare Inspectorate Wales
Dinene Rixon	Review Manager	Healthcare Inspectorate Wales
Debra Bennett	Peer Review Programme Lead	South Wales Cancer Network

Network Title	South Wales Cancer Network	
Organisation Title	Abertawe Bro Morgannwg University Health Board	
Team title	Swansea MDT	
Review Date Title	22nd January 2014	
Name	**Job Title**	**Organisation**
Jon Featherstone	Consultant Urologist (MDT Lead)	Abertawe Bro Morgannwg University Health Board
Michelle Griffiths	Urology CNS	Abertawe Bro Morgannwg University Health Board
Russell Banner	Consultant Oncologist	Abertawe Bro Morgannwg University Health Board
Delia Pudney	Consultant Clinical Oncologist	Abertawe Bro Morgannwg University Health Board

Mau-Don Phan	Consultant Oncologist	Hywel Dda Health Board
Pradeep Bose	Consultant Urologist	Abertawe Bro Morgannwg University Health Board
Prof John Wagstaff	Consultant Medical Oncologist	Abertawe Bro Morgannwg University Health Board
Amol Pandit	Consultant Urologist	Abertawe Bro Morgannwg University Health Board
Beth Birch	Consultant Palliative Medicine	Abertawe Bro Morgannwg University Health Board
Hywel Thomas	Consultant Pathologist	Abertawe Bro Morgannwg University Health Board
Ciaran O'Brien	Consultant Pathologist	Abertawe Bro Morgannwg University Health Board
Sam Williams	ADGM Surgery	Abertawe Bro Morgannwg University Health Board
Neil Fenn	Consultant Urologist	Abertawe Bro Morgannwg University Health Board
Bev James	Urology CNS	Abertawe Bro Morgannwg University Health Board
Cath Dixon	Urology CNS	Abertawe Bro Morgannwg University Health Board
Sohail Moosa	Consultant Urologist	Hywel Dda Health Board
Melanie Simmons	Directorate Performance Manager	Abertawe Bro Morgannwg University Health Board
Marisa Bennett	Directorate Support Manager	Abertawe Bro Morgannwg University Health Board
Amy Burgess	MDT Co-ordinator	Abertawe Bro Morgannwg University Health Board

Network Title	South Wales Cancer Network	
Organisation Title	Abertawe Bro Morgannwg University Health Board	
Team title	Princess of Wales Bridgend MDT	
Review Date Title	22nd January 2014	
Name	**Job Title**	**Organisation**
Andy Thomas	Consultant Urologist (MDT Lead)	Abertawe Bro Morgannwg University Health Board
Sue Rowland	Urology CNS	Abertawe Bro Morgannwg University Health Board
Alison Townsend	Nurse Practitioner	Abertawe Bro Morgannwg University Health Board
Hywel Thomas	Consultant Pathologist	Abertawe Bro Morgannwg University Health Board
Gareth Tudor	Consultant Radiologist	Abertawe Bro Morgannwg University Health Board
Nachi Palaniappan	Consultant Oncologist	Velindre NHS Trust
Tudor Young	Consultant Radiologist	Abertawe Bro Morgannwg University Health Board
Graham Hirst	Staff Grade Urology	Abertawe Bro Morgannwg University Health Board
Rob Skyrme	Consultant Urologist	Abertawe Bro Morgannwg University Health Board
Raj Nirula	Consultant Urologist	Abertawe Bro Morgannwg University Health Board
Rhidian Hurle	Consultant Urologist	Abertawe Bro Morgannwg University Health Board
Sam Williams	ADGM Surgery	Abertawe Bro Morgannwg University Health Board
Jessica Morgan	MDT Co-ordinator	Abertawe Bro Morgannwg University Health Board
Melanie Simmons	Directorate Performance Manager	Abertawe Bro Morgannwg University Health Board
Marisa Bennett	Directorate Support Manager	Abertawe Bro Morgannwg University Health Board

REVIEWERS REPORT

Key Themes

1 Structure and Function of the Service

There are 2 Urology MDT's within the Abertawe Bro Morgannwg University Health Board. One held at Morriston Hospital, Swansea and One at the Princess of Wales Hospital, Bridgend.

There was commitment in the completion of the Self Assessment documentation by both teams and all members said they had seen the information prior to submission, and the document was signed off by the MDT Lead. The team were highly commended for the content and the information contained in their self assessment submission and the attendance at the Review visit.

Swansea MDT

The Swansea MDT is held at Morriston Wales Hospital, Services have recently moved from Morriston hospital to a new diagnostic unit at Neath Port Talbot hospital. Due to this, there was initially a capacity issue with regards diagnostic tests, but this issue is now being addressed. The current MDT facilities are inadequate, but ABMU are currently completing a new build on the Morriston site, and a dedicated MDT room will hopefully be available when it opens later in the year.

The MDM Module is used administratively by the MDT Co-ordinator but not live at the MDT Meeting. The Co-ordinator generates minutes following the MDT meeting and sends round to the team for checking and then enters the discussion into Canisc. The module is not used live due to the large number of patients discussed each week and the current MDT facilities being inadequate. This could be addressed when new facilities become available.

There is no Radiology attendance at the MDT Meeting. A separate Radiology meeting is held on a Monday lunch time but there is no Oncology input at that meeting. This has been raised with the lead for Radiology, where support for the MDT has been agreed, but nothing has happened to address this to date. The plan is to have 3 or 4 Radiologists cover the MDT on a rota basis. It was noted that there was no Consultant Radiologist present at the review meeting. Palliative Care also has no attendance at the MDT meeting although it was felt there were good referral pathways to this specialty, and palliative care was well and enthusiastically represented at the review meeting.

There are a number of internal audits that have been carried out by the MDT. There are no regular Business meetings held outside of the MDT to look at pathway issues, guidelines etc, but there is an all day meeting planned later in the summer to look at these. The previous meeting took place about 2 years ago. The MDT hold monthly M&M meetings where all relevant patients are discussed. These patients are identified via the Chemotherapy and PAS systems. There is also a 30 day post chemotherapy mortality meeting held every 3 months in Singleton. Recruitment into clinical trials is excellent, and the team asked that this be reflected within this report, as a lot of work had been undertaken by Clinical Oncology to address this.

Patients are informed of their diagnosis of cancer via a telephone results process. This process has been audited via a patient survey, and the results were very positive.

There was poor compliance with the 62 day Cancer Waiting Times Targets. (Prostate 70%, Bladder 62%). There are a number of contributing factors such as the transfer of services from Morriston Hospital to Neath Port Talbot hospital, PSA waits and issues around diagnostic tests. Trackers are in place and weekly meetings are held looking at the patient pathways, and there is also now one PAS system within the Health Board.

The time to TURBT is 77 days, which is one of the longest waits within Wales. This will inevitably delay treatment of patients found to have muscle invasive bladder cancer. Only 8/13 (62%) patients with muscle invasive bladder cancer were treated within the aspirational target of 93 days.

GP's are not being notified of diagnosis within 24 hours of the diagnosis being discussed at the MDT, This was due to GP's not wanting to know about the diagnosis until the patients had been informed. There was no evidence that this had been audited.

Improvement of communication with Primary Care was seen as a challenge, although there have been good interaction with Trainee GP's, training session was set up 2 years ago for West Wales GP's to highlight modern systemic management of kidney cancer, but only 15 people showed any interest in attending. One of the Oncologists has been approached by the GP Prescribing leads to set up regular educational sessions. A Bladder day was set up in West Wales and there was very good attendance. A Men's Health Day is currently held Annually which includes GP's, and they have asked that this be held Bi-annually. GP's have access to the Health Board website. There have been no GP surveys with regards to the service they receive from secondary care.

There have been problems with bed capacity. Patients are admitted at 6pm the day before surgery, and it was planned to have a Day of Surgery Admission (DSA) unit, but this hasn't happened to date. Due to geography, patients from the Pembrokeshire and Aberystwyth area coming to Swansea for Surgery will still have to be admitted the day before and the team were adamant that they would only develop DSA if suitable DSA facilities were provided.

There have been issues with regards to access to Oncology services. During the period reviewed the wait for 1st Appointment with an Oncologist was 6-8 weeks, and the wait for Chemotherapy over 3 weeks. There is no routine referral to the Oncologist for bladder patients for consideration of neo-adjuvant chemotherapy for bladder cancer. This appeared to be due to both a lack of Oncology capacity as well as a preference for primary surgery. For example, of 18 patients with muscle invasive bladder cancer patients, only 1 patient received Neo-adjuvant chemotherapy. A retrospective audit of these patients suggested that only a minority of these patients would have been suitable for neoadjuvant therapy. The reasons for this were unclear.

A business case was put forward in 2010 for a Uro-Oncologist post; the post was only appointed to in February 2013. There has been a lot of work to improve Radiotherapy services, and the introduction of IMRT within the Cancer Centre in Swansea over the past 2 years has led to all 'prostate and pelvic node' patients receiving IMRT.

An Acute Oncology Service is currently being developed. A CNS has recently been recruited at Singleton Hospital to carry out a pilot. The Health Board are fully committed to the process and a business case is currently with the executive team for consideration for funding. All chemotherapy is carried out at the Cancer Centre in Swansea, where there is 24 hour

access to Oncology services.

A Metastatic Spinal Cord Compression (MSCC) pathway is being developed. Emergency surgery is carried out at Cardiff, with less urgent cases being operated on in Swansea. A MSCC Forum has been set up which meets weekly and where all patients are discussed.

Laparoscopic work for Radical Prostatectomy is very good with 32 out of 58 (55%) Radical Prostatectomies being carried out laparoscopically.

Bridgend MDT

The MDT should be commended for undergoing significant reconfiguration to implement the NICE improving outcomes guidance of 2002, with relocation of complex pelvic surgery to Morriston. The team appeared cohesive with excellent leadership demonstrated by the Urology clinical nurse specialists. The MDT is held at the Princess of Wales Hospital, Bridgend. There was lack of cross cover for Pathology (20%), and Oncology (27%) representation at the MDT.

There is a split Oncology pathway, chemotherapy and radiotherapy is currently carried out in Velindre Hospital for patients with 'CF' post codes, and Singleton hospital for patients with 'SA' codes. There is only input at the MDT by a Velindre Oncologist with no cross cover, and no input from Swansea Oncology. If patients are referred to Swansea, they have to be discussed at the Morriston Urology MDT before being seen by the Oncologist or be seen and follow the advice given by the Velindre oncologist and this can cause delays in the pathway. It was felt that the input of Singleton Oncology at the MDT was important, and would cut back on delays in the pathway. If the waiting lists in Neath Port Talbot Hospital increase, the patients are referred to the Bridgend locality where the investigations can be carried out. During August 2013 due to the increase in demand, extra TRUS Biopsy clinics were set up in Bridgend to address the back log. Although this has the potential to decrease waiting times overall, it seemed that there was a lack of coordination over this process and made it difficult to plan patient flows at POW.

The Radiologists attend approximately 4 different site specific MDT's per week, and preparation time to cover all 4 MDT meetings is not included in their job plans. There are a large volume of reports, and scans are not reviewed prior to the MDT meeting which results in images being reported on in detail during the meeting. There are 4 Radiologists who report on scans but only 2 attend the MDT Meeting, so often scans are being reviewed that haven't been carried out by the attending Radiologists. It was noted that the wider radiology service is very good.

The Pathologists only have 1 session within their job plans to prepare and attend the MDT meeting and some Pathologists attend up to 3 site specific MDT meetings per week. There used to be 3 WTE Pathologists in post, but currently there are 1.6 WTE in post which shortly will reduce to 1WTE Consultant Pathologist. There have been problems recruiting to the vacant posts. This issue has been raised at Executive level and Risk assessments have been undertaken and there appeared to be plans to centralise pathology support in Swansea.

It was noted by the panel that the Laparoscopic conversion rate in the information section (for 2012) was quite high at 20%. The panel were informed that during the review period large tumours were resected via Laparoscopy and then converted to open procedure. It was recognised that the POW surgeons were not getting enough exposure to the laparoscopic

technique and so patients requiring Laparoscopic surgery are now being referred to Swansea. No laparoscopic surgery has been carried out in Bridgend for the past 7 months. Again the team were to be commended on supporting service reconfiguration.

The MDM module is used live but not displayed within the MDT Meeting. It was not clear why this is the case. Outcomes are checked by the team.

There is an issue with the availability of case notes at the MDT meeting. This a Health Board wide issue which the whole MDT felt was very unsatisfactory. On occasion only temporary sets of notes are available, as patients are seen in different hospital within a couple of days, and also if there are multiple volume's of case notes, not all are available at the meeting as the older volumes are stored off site. Currently there are 3 hospital numbers in use across the Health Board, and notes are ferried between hospitals via hospital transportation. The co-ordinator makes every effort to ensure that case notes are requested and to ensure they are present at the MDT. Currently notes are being scanned with a view to moving towards an electronic case note system. There are proposed thoughts around the clinical portal.

The Team do not operate a one stop clinic approach. The patients are seen in clinic and then return for their TRUS biopsy. After a positive diagnosis decisions on staging investigations are made prior to the patient receiving their initial results. The Nurse Practitioner then contacts the patient with regards to attending for investigations, and the patient then attends clinic for the results and to discuss treatment options.

The team are currently aspiring to improve the process for the patients, and are going to be trialling a new mini tablet device, where patients will be given I-Pads which will contain all information with regards to their pathway, treatment options etc. Appointments will be sent to the device, and there are videos about the hospital, MDT members and any relevant advice about their cancer type. Initial work will be carried out as a pilot to determine if there are patients unsuitable for this type of working.

Staging investigations are carried out in a timely manner. If the waiting lists in Neath Port Talbot Hospital increase, the patients are referred to the Bridgend locality where the investigations can be carried out. During August 2013 due to the increase in demand, extra TRUS Biopsy clinics were set up in Bridgend to address the back log.

There was poor compliance with the 62 day Cancer Waiting Times Targets.

Prostate 31% Q4 2012/13 – 57% Q2 2013/14

Bladder 50% Q4 2012/13 – 50% July 2013

There has been an improvement for Renal 25% Q3 2012/13 – 100% July 2013

This was largely thought due to issues with the booking of first appointments, where there have been issues with staffing within the booking department and a turnover of staff on a regular basis, and clinicians and Cancer Services having no control over the booking system. There is also a long wait for Prostate and Bladder appointments. There are plans in place to cut back on the number of steps to booking first appointments. There is a small number of support staff and their responsibilities have been expanded to support the service. It was felt that there were no written pathways in place, and no mapping exercise had been carried out to look at this formally.

Patients with suspected prostate cancer follow a well established pathway, although this is

not written down. They are counselled in clinic prior to coming back for a TRUS biopsy, rather than the one stop clinic model used in Morriston. Decisions on staging investigations are made prior to the patient receiving their results. The Nurse Practitioner (working with the consultant) then contacts the patient with regards to attending for investigations, and the patient then attends clinic for the results and to discuss treatment options. There is a 'tracker' in place who tracks all the patients through their pathway, and the CNS meets with the tracker weekly to try and address any issues with the pathway

There is also an issue with regards to pre-assessment clinic appointments. Previously there was a walk in process where a date was given to patients at the time of request. This issue has been flagged up and the pre assessment module is being looked at.

There is a 'tracker' in place who tracks all the patients through their pathway, and the CNS meets with the tracker weekly to try and address any issues with the pathway. Once Biopsies are taken, the CNS tracks the results.

The time to TURBT is 68 days, which was considered too long. There are a number of Clinicians carrying out TURBT, and there is flexibility for moving sessions to accommodate waiting lists. All TURBT's are carried out at the Princess of Wales Hospital. If patients are unable to travel to Bridgend, they are seen in Swansea. For Muscle invasive bladder cancers to additional treatment only 16% of patients met the target. It was felt that due to the current issues with Oncology services that this target would never be met.

There is currently only 1 Endoscopic Stack, which means there is a limit to the number of procedures that can be carried out and prevents the team from carrying out parallel lists. There has also been an issue with the sterilization of flexible instruments, which resulted in lists having to be cancelled during December. This has been raised at Executive level.

Acute Oncology Service is currently being provided by Velindre Hospital, where there is 24 hour service, and patients are given the contact details of the Velindre Chemotherapy CNS. There did not appear to be any clear plans to develop a service in Bridgend. This was felt particularly important due to the complex pathways which varied for tertiary surgical and oncology services, being west and East, respectively. Metastatic Spinal Cord Compression (MSCC) services are available via the Oncologist at Velindre Hospital. Unfortunately, there is no access to 24 hour MRI at weekends.

Links with Primary Care are very good. There are educational events that are organised and GP's are invited to attend, and there are regular evening talks with GP's. All information is available on the Health Board website which the GP's have access to.

2 Patient Centred Care and Experience

Swansea MDT

There are 4 CNS's in post who cover sub specialities within Urology, but it was noted that there was no dedicated CNS for Renal patients. The previous senior CNS use to see Renal patients, but has since left this post to take on another role. CNS's can be contacted 24 hours on weekdays via an answer machine. Breaking bad news is generally carried out by the Consultant, but can occasionally be carried out by the CNS.

The team participated in a 2011 Network Patient survey. A number of issues were raised that had not been clearly addressed. The team were commended for having already

reviewed the results of the recent Wales Cancer Patient Experience Survey, which showed very good results for the Urology service

It was noted that there was an excellent Enhanced recovery pathway in place.

Bridgend MDT

There are 2 CNS's in post for Urology, but there is no dedicated CNS for Renal patients. Renal patients are only seen as inpatients when they attend for surgery. There is limited cross cover due to workloads. Holistic needs assessment is not carried out. This has been looked at by the CNS's, but due to this being very time consuming, was found to be difficult to put in place. No written Care Plan developed but contact details are given.

Patient surveys have been carried out and there was found to be very little negativity in the outcomes. The team have also participated in the recent Macmillan patient survey, the results of which have been seen by the Health Board, and the results for Urology are known to be good.

a. Evidence of Key worker

Swansea MDT

The CNS generally takes on the role of Key Worker, but this role is taken on by the Consultants in some cases. This was noted to be unusual. There was no evidence of a key worker being recorded in the patient's case notes or on Canisc. Prostate patients generally know who their Key Worker is prior to a diagnosis of cancer being made.

Bridgend MDT

The role of Key Worker is undertaken by the CNS's. There was no evidence of a key worker being recorded in the patient's case notes or on Canisc.

3 Service Quality and Delivery

Swansea MDT

In general the team was well supported. Whilst there was no Palliative Care input at the MDT, there were good referral pathways in place. There was also no Radiology input at the MDT, with a separate Radiology meeting being held, but it was noted that the support from the wider service was very good. There are currently 2 radiology systems in place within the Health Board. There are plans in place across Wales to look at an All Wales Radiology PACS system.

There is access to Psychology services at the Maggie Centre, Singleton Hospital, where there is a short wait to see patients. There is also access to a Psychosexual councillor at Neath. Palliative Care are currently working on a business case for NHS based Psychology support.

There is a shortage of Histopathologists, but there is good attendance at the MDT. There is currently another Consultant Histopathologist developing an interest in Urology. There is an excellent turnaround of prostate biopsy results which is within 5 working days.

Bridgend MDT

There is excellent support in terms of attendance from Cancer Services, Radiology and the CNS's. There is access to Psychology services at the Maggie Centre, Singleton Hospital, where there is a short wait to see patients. There is also access to a Psychosexual councillor at Neath. Whilst there was no Palliative Care input at the MDT, there were good referral pathways in place.

All Patient Information has been standardised across the Health Board.

There is no access to the Clinical Portal to access results. There are currently 2 systems in place within the Health Board, but there are plans to move to 1 system later in the year.

a. Service Outcome Data

	Morriston	Princess of Wales	Neath Port Talbot	Target
Number of USC referrals treated within 62	Prostate 44/63 (70%) Bladder 8/13 (62%) Renal 17/18 (94%)	Prostate (57%) Bladder N/A Renal 0%	Prostate (57%) Bladder N/A Renal 0	95%
Number of non – USC referrals treated within 31 days	Prostate 96/96 (100%) Bladder 17/17 (100%) Renal 8/12 (67%)	Prostate (100%) Bladder (100%) Renal (100%)	Prostate (100%) Bladder (100%) Renal (100%)	98%
Number of patients with Pre-treatment stage recorded	Prostate 158/177 (89%) Bladder 31/31 (100%) Renal 16/44 (36%)	Prostate 126/150 (84%) Bladder 32/34 (94%) Renal 12/38 (31.5%)	Prostate 2/4 (50%) Bladder 2/2 (100%) Renal ??	70%
Number of patients entered into clinical trials	143/ 294 (49%)	11 (5%)	0	10%
Number of patients donating to Wales Cancer Bank	95	0	0	
Number of patients discussed at MDT	Prostate 251 (regional) Bladder 31/31 (100%) Renal 26/26 (100%)	Prostate 150/150 (100%) Bladder 34/34 (100%) Renal 21/21 (100%)	Prostate 4/4 (100%) Bladder 2/2 (100%) Renal 5/5 (100%)	100%
Median time for patients with muscle invasive TCC Bladder start of definitive curative treatment	8/13 (61.5%)	8/13 (61.5%)	121.5 Days	93 Days
Median time to TURBT	77 Days	77 Days	68 Days	

Key audits projects and outcomes

Swansea MDT

An audit of delays in MDT discussion due to delayed Histopathology specimen transfer from West Wales was undertaken. The issue was raised with the Cancer Lead Clinicians in both Hywel Dda and ABMU and the protocol for MDT referral reissued. At re audit there was seen to be significant improvement. Apart from BAUS, there is no National Urology Audit.

Bridgend MDT

The team are currently auditing the use of 'Blue Light' Cystoscopy technology to improve detection and treatment of bladder cancer.

General Observations

Recording of pre-treatment stage was low for Renal cancer Swansea MDT (36%) and Bridgend MDT (31.5%).

4 Review of Clinical Information in the Clinical Notes and Canisc

Swansea MDT

Review of 4 case notes using the peer review check list showed no evidence of recording of the Key Worker, only 2 of the 4 case notes had notification to GP within 24 hours of diagnosis. All case notes had Care plans recorded, but only 1 of the 4 had seen by CNS recorded and 3 of the 4 had a Cancer Management Plan recorded.

On checking the same case notes in Canisc, again there was no evidence of the recording of the Key Worker, Notification to GP within 24 hours of diagnosis or seen by CNS. Care plans and Cancer Management Plans were recorded in 3 of the 4 case notes.

Bridgend MDT

Review of 5 case notes using the peer review check list showed no evidence of recording of the Key Worker, 4 of the 5 case notes had notification to GP within 24 hours of diagnosis. All case notes had Care plans recorded, but only 2 of the 5 had seen by CNS recorded and 1 of the 5 had a Cancer Management Plan recorded.

On checking the same case notes in Canisc, again there was no evidence of the recording of the Key Worker or Notification to GP within 24 hours of diagnosis. Seen by CNS, Care plans and Cancer Management Plans were recorded in 3 of the 5 case notes.

5 Engagement with Management

Swansea MDT

There are monthly Directorate meetings and Bi-annual Cancer Executive meetings. A group is due to commence in April to look at the Cancer Delivery plan (CDP). The CDP has been shared with the Urology team, and an action plan for each tumour site has been developed.

The MDT reported that they had been fully involved in the Peer Review Process, including the evidence gathering and data submission This was evident in the content of the self assessment submission.

Bridgend MDT

Cancer currently sits within 3 different directorates. The team said it had great difficulty engaging with service management teams, and there is split leadership within the Directorates with split roles. The panel felt this could lead to a lack of clarity as to where responsibility for cancer services sat within the management structure in Princess of Wales. There has been no dedicated management support due to sickness etc over the past 3 years. A new manager is due to take up post in the next couple of weeks and will meet with the clinical team to discuss any issues.

There appeared to be a consensual view that services had deteriorated in terms of infrastructural support since the incorporation of POW into ABMU Health Board.

The Health Board operate an open style of management, and due to the small size of the hospital, communication is very good.

The team were not involved in the development of the Health Board Cancer Delivery Plan, but have had sight of the document. There is a Delivery plan workshop due to take place in March 2014.

The MDT reported that they had been fully involved in the Peer Review Process, including the evidence gathering and data submission This was evident in the content of the self assessment submission.

Currently the Deputy Directorate manager attends the weekly tracking meetings

6 Culture of the Teams

Swansea MDT

The panel noted that there was an excellent working relationship within the team and with tertiary hospitals. Following the death of one of the senior Consultants in West Wales, initially all surgery was referred to Swansea. This has now been addressed with the team mentoring colleagues at the tertiary Health Board, who now are able to carry out the procedures in house.

There had been excellent engagement with the peer review process, the self assessment return was exemplary, which the review team felt was typical of the desire of the Swansea MDT to deliver a high quality of service to patients, an enthusiasm to improve this in some areas and an acknowledgement of where further challenges lay.

Bridgend MDT

The panel noted that there was an excellent working relationship within the team.

The MDT seemed unaware of the existence of the MDT Charter but in particular it was felt that the MDT would really benefit from dedicated ‘business meetings’ to look at patient pathways, audit and service improvement initiatives. This could lead to clearer articulation of service support needs like dedicated time in job plans of radiology and pathology.

There was clearly a perception in the MDT that there was not full engagement with POW MDTs by ABMU management and that radiology and pathology services for example were under resourced, and patient flows and pathways were outside the control of the clinical team.

GOOD PRACTICE / SIGNIFICANT ACHIEVEMENTS

Swansea MDT

- There were excellent working relationships within the team and involvement with the peer review process, demonstrating pride in excellent service developments and candour with issues that need to be addressed
- Development of an IMRT Service at Singleton
- Turnaround of prostate biopsy results within 5 working days
- Laparoscopic work for Radical Prostatectomy
- Introduction of an enhanced recovery pathway
- Introduction of transperineal template biopsies

Bridgend MDT

- Introduction of an IPAD mini tablet device for patient Information along the pathway.
- DEXA Scanning of patients on long term endocrine therapy
- Reconfiguration of urological surgical services
- Introduction of Blue Light cystoscopy to improve treatment of bladder cancer.

IMMEDIATE RISKS

None

SERIOUS CONCERNS

Swansea MDT

- Lack of Radiology attendance at the MDT Meetings.

Bridgend MDT

None

CONCERNS

Swansea MDT

- Non compliance with the 62 day target
- There are no Business meetings held outside of the weekly MDT meeting
- The under use of neo-adjuvant chemotherapy for bladder patients
- Significant wait for 1st Appointment with Oncologist 6-8 weeks
- The wait for starting chemotherapy is over 3 weeks
- No dedicated CNS for Kidney Patients despite excellent site specific support for other sub-sites

Bridgend MDT

- A perceived lack of engagement by ABMU management in POW MDTs
- No time in job plans of Radiologists for preparation for MDT Meetings
- Radiologists who attend the MDT may not have reported on the scans they are reviewing
- Non compliance with the 62 day target
- There is no dedicated CNS for Kidney Patients
- Only 1 Endoscopy stack, leading to capacity problems
- Case notes not available for MDT Meeting
- Lack of cover for the Oncologist
- There is no input from Singleton based oncologists at the MDT, despite the fact that some patients receive oncology services at that centre.