# Peer Review of Urological Cancer Services in Wales

# All Wales Summary Report 2015

Cancer National Specialist Advisory Group for Urological Cancers

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# Contents

## Introduction to peer review

Peer review is a quality assurance programme of the services delivered by health boards (HBs) and their multi-disciplinary teams (MDTs) 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 clinical review that not only ensures 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 is based on the requirements of the National Cancer Standards[1] 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 improvement.

The evidence considered by the peer review team came from both face to face interviews and data on clinical pathways and processes[2]. It is important to note that the key findings from each peer review visit, presented below, relate to information provided by each MDT and discussions on the day including a review of a limited number of case notes. As a result, the information presented in this report may not reflect current services now being provided. This is in keeping with all peer review methodologies.

This peer review focussed on the common urological cancers of the prostate, bladder and kidney with penile cancers being the subject of a separate review. Peer review visits were held during January and February 2014.

## Introduction to services for urological cancers

Management of cancer forms a significant proportion of a general urologist's routine work. Diagnosis and treatment are managed by MDTs with specialist expertise in these cancers. The teams include urologists, radiologists, pathologists, oncologists, palliative care clinicians, clinical nurse specialists and a co-ordinator. Team meetings are essential and facilitated by videoconferencing to enable specialists, often based in other hospitals, to input into the specialist MDT discussions on each case and agree clinical management options to be discussed with the patient.

[1] National Cancer Standards for Urological Cancers 2005
http://www.wales.nhs.uk/sites3/documents/322/National_Standards_for_Urological_Cancer_Services_2005_English.pdf

[2] Data submitted was for 2011

Patients requiring complex surgery for prostate or bladder cancer will be managed by an MDT which specialises in these surgeries. Similar arrangements apply for patients requiring complex surgery for kidney cancer. These arrangements allow for specialisation to be developed and maintained with services running throughout the year.

For further details of requirements for patient centred care, the MDT, access to support staff and best clinical practice please see the National Cancer Standards.

## Components reviewed

The key findings highlighted in this all Wales summary have been collated from each HB's Peer Review report. These reports cover the following aspects;

1. Structure and Function of the Service
2. Patient Centred Care and Experience
3. Service Quality and Delivery
4. Review of Clinical information in the Clinical Notes and Canisc[3]
5. Engagement with Management
6. Culture of the Teams
7. Good Practice and Significant Achievements
8. Immediate Risks
9. Serious Concerns
10. Concerns.

Acronyms used for HBs are summarised in Appendix 1.

## Key findings[4]

| | |
|---|---|
| Good practice and service improvement | •Peer review found examples of good practice and areas for improvement in all health boards |
| Serious concerns | •Serious concerns were reported in three health boards |
| Immediate risks | •No health board found to have an immediate risk |

### 1, 2. Structure and Function of the Service and Patient Experience

A number of components sit within these categories relating to the GP referral pathway, the location of MDTs, access to a key worker and provision of specialist services. Various service models have been developed across Wales with the aim to provide prompt diagnosis and clinical pathway for patients diagnosed with a urological cancer.

[3] All Wales electronic patient record used for clinical management of patients
[4] See Appendix 2 for definitions of risk

Certain MDTs were commended for excellent support from radiology, pathology and oncology (HDUHB; C&VUHB). The extensive role of the Clinical Nurse Specialist (CNS) was clearly identified across Wales as was the impact on services where shortages in CNSs were reported. The CNS was confirmed as the patient's key worker in nearly all MDTs and it was clear they had a key role in establishing nurse-led clinics both as part of the diagnostic and post treatment follow up pathways.

A number of MDTs were commended for having developed laparoscopic 'key hole' surgery with examples being in BCUHB, HDUHB and ABMUHB. In South East Wales a different approach has been taken with C&VUHB implementing a regional robotic surgical service for prostate cancer, initially for South East Wales and subsequently for South Wales.

## 3. Service Quality and Delivery

MDTs were asked to provide data in support of service quality and delivery. Unlike some other cancers, urological cancer services have not had the benefit of having a national clinical audit to benchmark services. As a result, the data available for peer review were sometimes limited[5]. This has had an impact on clinical audit, considered an essential tool for service improvement.

Despite these limitations, examples of clinical audit resulting in improved services were noted for MDTs in ABMUHB, CTUHB and ABUHB.

Measuring clinical outcomes such as mortality and survival are often challenging particularly where these are best presented on a population basis and where changes are gradual over time. To address this, clinical indicators are used as proxy measures for outcomes and the following were selected to provide an overview of the main stages in the clinical pathway from referral to treatment. The first three of these are generic, applying to prostate, bladder and kidney cancer services. The remaining four focus specifically on prostate (2) and bladder cancer (2).

### *3.1 Waiting times[6]*

**Why these are important:** Prompt treatment is very important in optimising the outcomes in bladder, kidney and testicular cancer. While treatment delays are of less clinical significance in many patients with prostate cancer, they are still a major concern as they can exacerbate anxiety for patients and their families and carers. For patients referred from their GP as urgent with suspected cancer (USC) the waiting times pathway allows for a month to proceed to a diagnosis followed by a further month to determine how advanced the disease is, discuss management options as a team and with the patient, and start treatment[7]. For patients not referred in this way (nUSC), but where cancer is an incidental finding, the waiting time pathway starts at the point that a member of the MDT discusses the treatment options with the patient, with a month in which to start treatment. **Findings**: Compliance to these waiting times show, as with a number of other cancers, that compliance with the 'USC 62 day' pathway is more challenging than for the 'non USC 31 day' pathway. Focussing on the 31 day nUSC wait, better compliance was noted for patients with prostate or bladder cancer compared to those with renal cancer. Data are summarised in Appendix 3 Figure 1 and Table 1.

[5] This is expected to improve in relation to prostate cancer as a result of the new Prostate Cancer Audit
[6] National Cancer Standards, 2005
[7] For prostate cancer patients this can include opting for watchful waiting

### *3.2 Number of patients discussed at the MDT (target 100%)[8].*

**Why this is important:** This metric is important as a proxy for the quality of care and management of each new patient diagnosed with cancer. The clinical management plan is discussed and options to be considered with the patient agreed by the MDT. **Findings:** Apart from one exception, compliance was found to be excellent for prostate and bladder cancer and more variation noted for renal cancer. Data are summarised in Appendix 3 Figure 2 and Table 2.

### *3.3 Patients with pre-treatment stage recorded (target 70%)*

**Why this is important:** This target is important because accurate staging, whether the cancer is localised or has spread, is crucial for making treatment choices and giving information to patients on prognosis. Information on stage distribution over time is expected to provide evidence of success in efforts to diagnose cancers earlier in their course. **Findings:** Pre-treatment stage was most comprehensively recorded and achieved for prostate cancer. For bladder and renal cancer more variation was noted with low levels of recording for this metric across BCUHB. The attainment of the relatively modest 70% target was challenging across all cancers and MDTs as shown in Appendix 3 Figure 3 and Table 3.

In addition to the above generic clinical indicators, the peer review team also considered two additional measures of good practice for each of bladder and prostate cancer.

### *3.4 The median time to trans-urethral resection of bladder tumour (TURBT).*

**Why this is important:** For patients with localised disease TURBT acts as both a diagnostic/staging procedure and treatment, as the tumour is removed. In such circumstances the USC-62 and nUSC-31 day targets apply. **Findings:** Wide variation was seen across HBs as shown in Appendix 3 Figure 4 and Table 4. This indicates that there is scope for service improvement initiatives to share best practice and reduce the waiting times to this procedure.

### *3.5 The median time for USC patients with muscle invasive TCC bladder[9] to start of definitive treatment[10].*

**Why this is important:** This is important for patients with more advanced disease as radical treatment[11], where indicated following TURBT, is not subject to cancer waiting times targets. Best practice was considered, by the National Specialist Advisory Group Urological Cancers Group, to expect radical treatment within a maximum of 93 days from receipt of referral[12]. This was circulated to Cancer Executive Leads of all Local Health Boards and all urological cancer MDTs in 2013. **Findings:** As these data have not been routinely collected before, the data are not robust enough for benchmarking. This metric will be reported as part of the next round of peer review.

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[8] National Cancer Standards, 2005
[9] Transitional cell carcinoma
[10] Cancer NSAG Urological Cancer Group god practice advice (letter to HBs January 2013)
[11] Radical treatment could be either cystectomy, external beam radiotherapy or neo-adjuvant chemotherapy
[12] Cancer Waiting Times (CWT) to First Definitive Treatment: Good Practice Metric for Patients with Muscle Invasive Bladder Cancer. January 2013

## 4. Review of clinical information in the clinical notes and the Canisc

Case notes for five patients were reviewed along with data held in Canisc to evidence whether each patient had a key worker, a care plan, and had been seen by a clinical nurse specialist. Information was also sought on whether there was a record of the MDT's discussion and associated management plan. Finally, evidence was sought to confirm whether the patient's GP had been informed of the diagnosis of cancer within 24 hours of the patient being informed.

The findings showed variation across HBs however this review did confirm that, in general and taking the information from both case notes and Canisc together, the above requirements had been achieved for most of the small number of patients considered.

## 5. Engagement with management

This was found to vary across MDTs with reports of good engagement with management where Cancer Services Groups were in place and chaired by a member of the HB's executive team (CTUHB; ABUHB and ABMUHB-S). Other MDTs reported that improvements were about to be implemented to ensure MDT clinical input to management discussions on cancer services (HDUHB; C&VUHB). At a strategic level, lack of engagement had resulted in no MDT clinical input to a HB's Cancer Delivery Plan. Clinical engagement with management was an issue across MDTs in BCUHB.

## 6. Culture of Teams

A number of MDTs were commended for showing patient focussed, enthusiastic clinical teams with strong clinical leadership (C&VUHB; CTUHB; HDUHB; ABUHB; ABMUHB).

## 7. Good practice and significant achievements

All MDTs were recognised as having good practices with many noted as having strong clinical leadership. The following, some cited previously, are examples of good practice across Wales. Full details of good practice are available in the LHB Peer Review reports.

1. Development of innovative clinical pathways to achieve timely diagnosis, staging and start of treatment were noted across Wales such as, nurse-led clinics supporting diagnosis and follow up (CTUHB; C&VUHB; BCUHB); Introduction of enhanced recovery (ABMUHB; C&VUHB); a new post of Urology Pathway Co-ordinator (C&VUHB) and turnaround of prostate biopsy results within 5 working days (ABMUHB).
2. Multiparametric MRI[13] combines various techniques that enable radiologists to better separate cancerous from non cancerous tissue. Implementation is challenging for already hard pressed radiology departments. C&VUHB, CTUHB and BCUHB reported that they were working through the service implications of the NICE recommendations with CTUHB already providing multiparametric MRI and moving to template biopsy.
3. Robotic surgery for prostate cancer was being planned for South Wales (C&VUHB) with laparoscopic services provided on a regional basis by BCUHB and ABMUHB. Laparoscopic 'key hole' surgery for renal cancer is provided by all health Boards.

[13] http://www.nice.org.uk/guidance/CG175

4. Intensity Modulated Radiotherapy[14] was provided by Velindre Cancer Centre in Cardiff and South West Wales Cancer Centre in Swansea for patients across South Wales. In North Wales IMRT is provided at the North Wales Cancer Centre, again as a regional service, for patients across BCUHB.
5. Very high levels of research (C&VUHB); excellent submission of samples to the Wales Cancer Bank (BCUHB-YG)
6. Good information for patients (BCUHB-YWM); a team of CNSs provide nursing support for patients (C&VUHB); introduction of iPAD Mini for patient information (ABMUHB-POW); The CNS as key worker[15] (C&VUHB; CTUHB; BCUHB (all); ABUHB; ABMUHB (all)

### 8,9,10 Concerns and Risks

Peer review considers three categories of risk, namely concerns, serious concerns and immediate risks. These are defined in Appendix 2.

All six HBs were noted as having a number of concerns. These were related to aspects of **structure** e.g. lack of dedicated urology wards; **management** e.g. two HBs were noted as having insufficient time allocated for MDT meetings limiting the number of cases discussed.; **staffing** e.g. vacancies, lack of cover and no recognition of time to attend the regular MDT meeting in job plans were also identified to varying degrees as common themes across a number of HBs. **process** e.g. non compliance to cancer waiting times; **information** e.g. lack of recognition of the importance of data to assure the HB and public of service quality; **patient focus** e.g. no local patient experience surveys; **clinical research** e.g. low levels of recruitment to clinical trials.

Only three HBs were identified as having serious concerns in addition to concerns. These were related to aspects of **management,** namely no consensus on service reconfiguration and a lack of succession planning in surgery and radiology (BCUHB), sub optimal organisation and leadership of the regional MDT(BCUHB), an oncologist working outside an MDT structure (HDUHB), failure to complete actions from a previous peer review visit relating to the acute oncology service (HDUHB); **staffing** no cover for the MDT oncologist (HDUHB), MDT meetings with no input from a radiologist (ABMUHB), significant shortages in CNSs impacting on quality of care for patients and limiting service development (HDUHB, BCUHB)**; process** patient delays/lost to follow up (BCUHB). To be assured of high quality services in the future, the peer review team confirmed that they would repeat peer review of BCUHB's urological cancer services in a year.

No HB was found to have an immediate risk.

## Next steps

Each HB has produced an action plan to address the points raised at peer review. These reports and action plans should be referred to if further detail, not presented here, is of interest. We expect these reviews to be a catalyst for improvement, with HB's actively monitoring progress against actions plans.

[14] http://wales.gov.uk/topics/health/cmo/committees/scientific/reports/imrt/?lang=en
[15] Not all recorded in the case note

HIW also takes note of the outcomes of peer review and other intelligence when considering its risk based approach to inspection and escalation. HIW currently hosts HB reports on its website in order to support the open and transparent reporting of conclusions. It is also expected that this information is easily available on HB websites. It is important to note that this report reflects the peer review findings at the time of the review and does not take account of service developments that have already been completed or may be planned to address the issues identified.

## Appendix 1 Health Boards, their associated hospitals and acronyms

| Health Board | Hospital | Acronym |
|---|---|---|
| Betsi Cadwaladr University Health Board | Ysbyty Gwynedd | BCUHB - YG |
| | Glan Clwyd Hospital | BCUHB - YGC |
| | Wrexham Maelor Hospital | BCUHB - YW |
| Hywel Dda University Health Board | Bronglais General Hospital | HDUHB |
| | Withybush General Hospital | |
| | Glangwili General Hospital | |
| Abertawe Bro Morgannwg University Health Board | Neath Port Talbot Hospital | ABMUHB – NPT |
| | Princess of Wales Hospital | ABMUHB - POW |
| | Morriston | ABMUHB - M |
| Cardiff & Vale University Health Board | University Hospital | C&VUHB |
| Cwm Taf University Health Board | Royal Glamorgan Hospital | CTUHB |
| | Prince Charles Hospital | |
| Aneurin Bevan University Health Board | Royal Gwent Hospital | ABUHB |
| | Nevill Hall Hospital | |

## Appendix 2 Definitions of Concerns

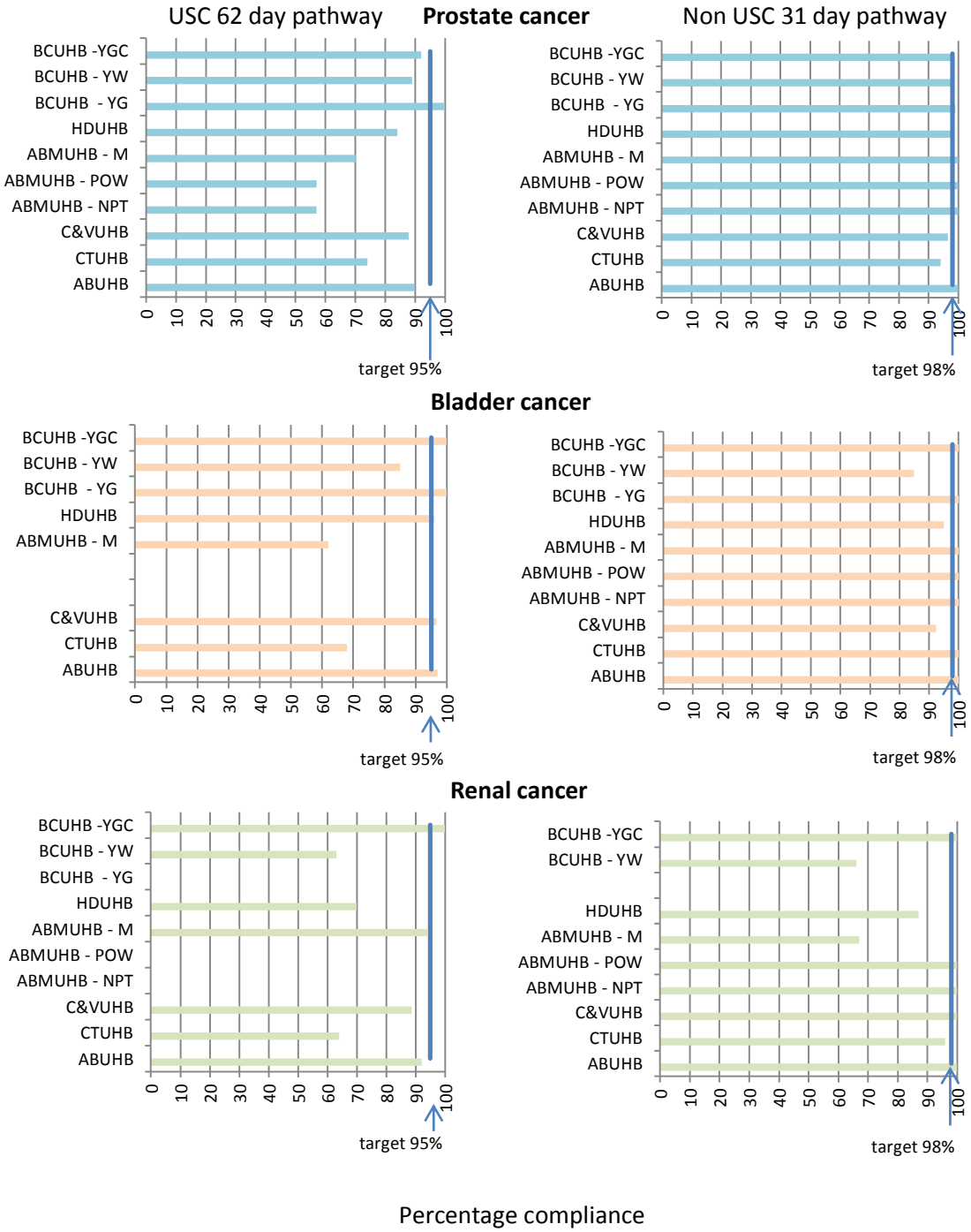
The lowest level of risk is referred to as a **concern**. This is an issue that affects the delivery or quality of the service that does not require immediate action but can be addressed through the work programme of teams/services.

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.

# Appendix 3 Data

**Figure 1 Compliance to the Urgent Suspected Cancer (USC) and non USC waiting times by cancer site and by UHB MDT[16]**




[16] UHBs not submitting data have been excluded

**Table 1 Summary of MDT percentage compliance by cancer site and for each of Urgent Suspected Cancer (USC) and non Urgent Suspected Cancer (nUSC) referrals**

| Cancer site | USC 62 day pathway target 95% days (number of MDTs providing data) | nUSC 31 day pathway target 98% (number of MDTs providing data) |
|---|---|---|
| **Prostate** | Lowest: 57% ABMUHB<br>Mean: 80%<br>Highest: 100% BCUHB-YG<br>(10) | Lowest: 94% CTUHB<br>Mean: 98.3%<br>Highest: 100% ABMUHB(all), ABUHB<br>(10) |
| **Bladder** | Lowest:62% ABMUHB-M<br>Mean: 88%<br>Highest: 100% BCUHB-YGC&YG<br>(8) | Lowest: 85% BCUHB-YW, HDUHB<br>Mean: 96%<br>Highest: 100% BCUHB-YGC&YG, ABMUHB(all), CTUHB, ABUHB<br>(10) |
| **Renal** | Lowest: 0% BCUHB-YG, ABMU-POW&NPT<br>Mean: 57%<br>Highest: 100% BCUHB-YGC<br>(10) | Lowest: 66% BCUHB-YW<br>Mean: 91%<br>Highest: 100% BCUHB-YGC, ABMUHB POW&NPT, C&VUHB, ABUHB<br>(9) |

**Figure 2 Percentage of newly diagnosed patients discussed at the MDT meeting by cancer site**

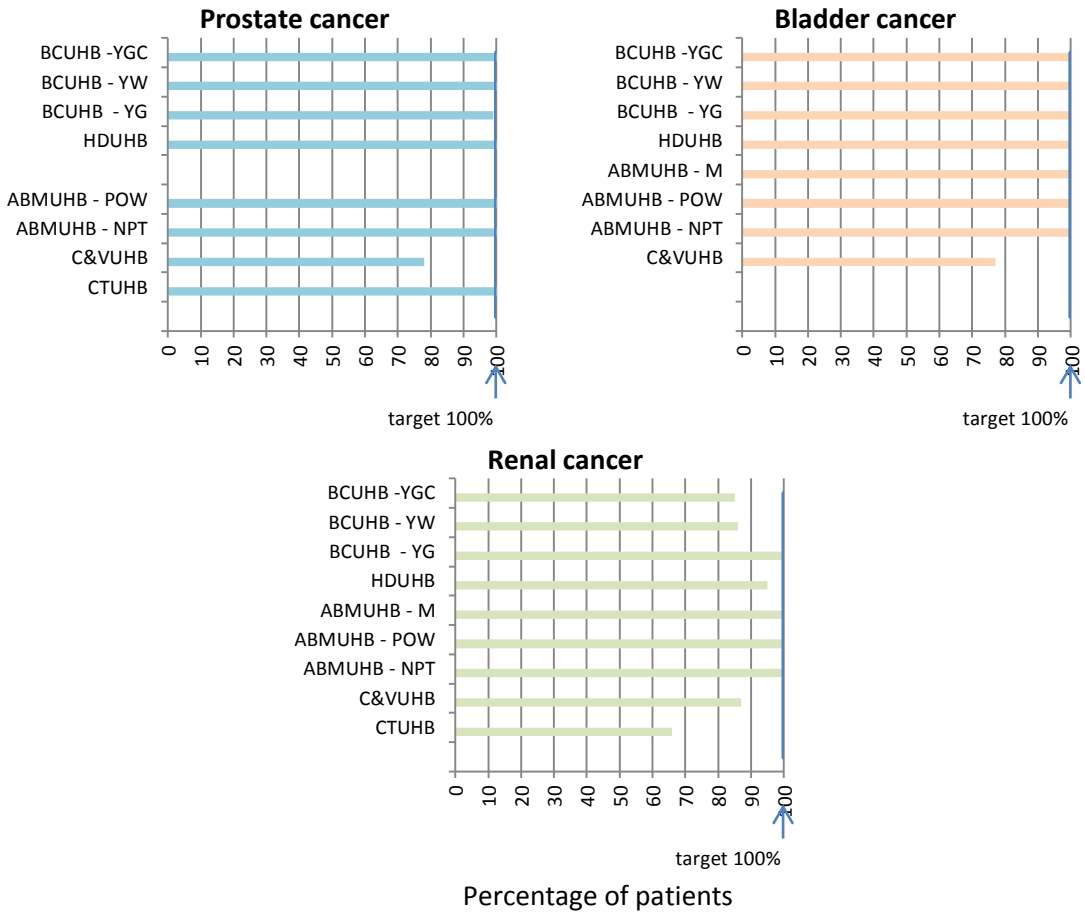
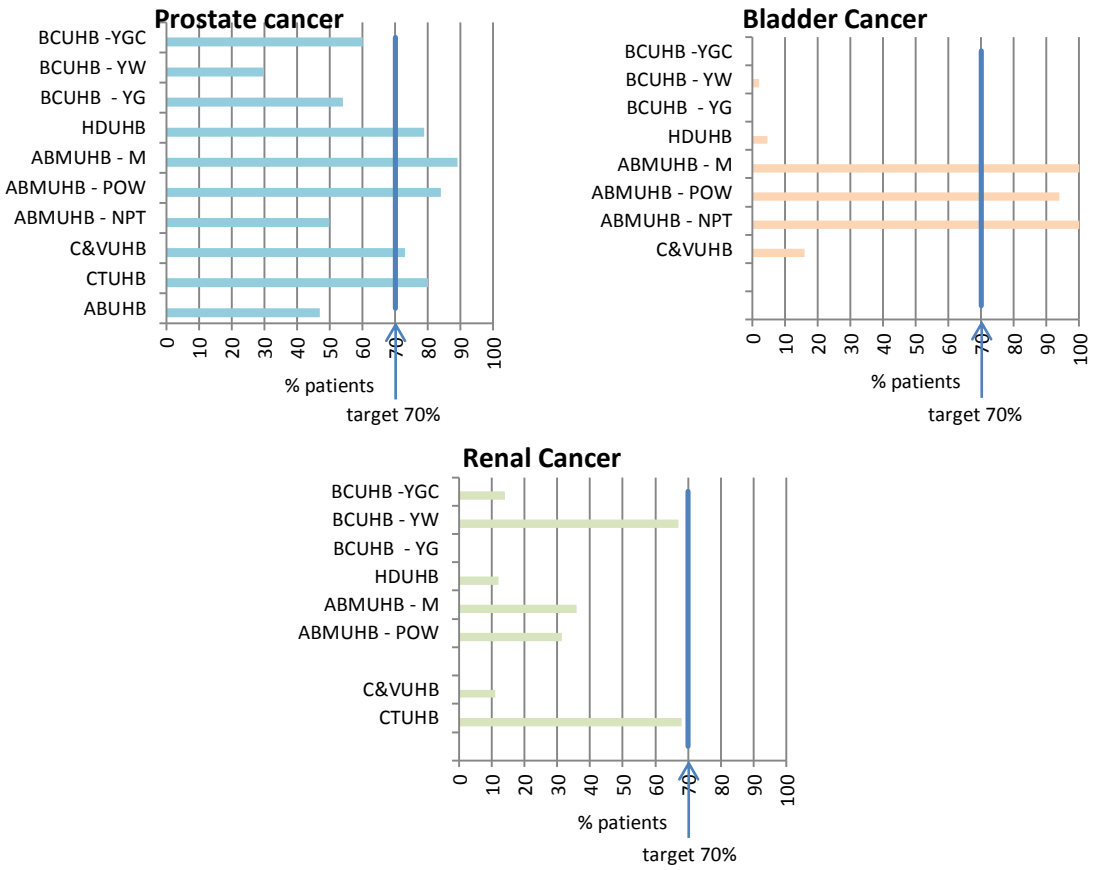



**Table 2 Summary of pooled data on the percentage of patients discussed at the MDT meeting by cancer site**

| **Cancer site** (number of MDTs providing data) | **% patients discussed at MDT - target 100%** |
|---|---|
| **Prostate** (8) | Lowest: 78% C&VUHB<br>Mean: 97%<br>Highest: 100% BCUHB-YGC&YW, HDUHB, ABMUHB-POW&NPT, CTUHB |
| **Bladder** (8) | Lowest: 77% C&VUHB<br>Mean: 97%<br>Highest: 100% BCUHB(all), HDUHB, ABMUHB(all) |
| **Renal** (9) | Lowest: 66% CTUHB<br>Mean: 91%<br>Highest: 100% BCUHB-YG, ABMUHB(all) |

**Figure 3 Percentage of patients with pre-treatment stage recorded by UHB MDT and by cancer site**




Percentage of patients with pre-treatment stage recorded

**Table 3 Summary of Percentage of patients with pre-treatment stage recorded by cancer site**

| **Cancer Site** (number of MDTs providing data) | **% patients with pre-treatment stage recorded Target 70%** |
|---|---|
| **Prostate** (10) | Lowest: 30% BCUHB-YW<br>Mean: 65%<br>Highest: 89% ABMUHB-M |
| **Bladder** (8) | Lowest: 0% BCUHB-YGC&YG<br>Mean: 40%<br>Highest: 100% ABMUHB-M&NPT |
| **Renal** (8) | Lowest: 0% BCUHB-YG<br>Mean: 30%<br>Highest: 68% CTUHB |

**Figure 4 Median time to trans-urethral resection of bladder tumour (TURBT) by UHB MDT**

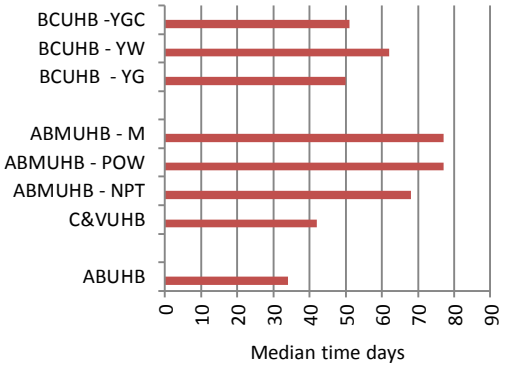



**Table 4 Summary of median time to TURBT**

| **median time to TURBT in days** (number of MDTs providing data) |
|---|
| Shortest time: 34 days ABUHB<br>Mean time: 58 days<br>Longest time: 77 days ABMUHB-M&POW (8) |