Urological CancersPeer Review 2014

Hywel Dda Health Board

Bronglais, Glangwili, Prince Philip & Withybush Hospitals

MEETING ATTENDANCE

Peer Review Team

Name	Job Title	Organisation
Ms Debra Bennett	Peer Review Lead	South Wales Cancer Network
Mr Bill Brereton	Lay Reviewer	Healthcare Inspectorate Wales
Mr Adam Carter	Consultant Urologist	Aneurin Bevan UHB
Dr Tom Crosby	Medical Director	South Wales Cancer Network
Ms Jane Hart	Lead Cancer Nurse	Aneurin Bevan UHB
Mr Hywel Morgan	Network Director	South Wales Cancer Network
Dr Nachi Palaniappan	Clinical Oncologist	Velindre NHS Trust

Network Title	**South Wales Cancer Network**	
Organisation Title	**Hywel Dda HB**	
Team title	**Bronglais, Glangwili, Prince Philip & Withybush Hospitals**	
Review Date Title	**4 February 2014**	
Name	**Job Title**	**Organisation**
Mr Bob Bowen	Deputy Head of Cancer Services / Lead Nurse	Hywel Dda HB
Mr Brett Denning	Asst. General Manager	Hywel Dda HB
Dr Norman Evans	Consultant Radiologist	Hywel Dda HB
Ms Donna Forrest	MDT Co-ordinator, Withybush	Hywel Dda HB
Dianne Griffiths	MDT Co-ordinator, Glangwili	Hywel Dda HB
Mr Baba Gana	Consultant Urologist	Hywel Dda HB
Mr Bashrat Jameel	Consultant Urologist	Hywel Dda HB
Ms Wendy Jones	Clinical Nurse Specialist	Hywel Dda HB
Mrs Jayne Mainwaring	Cancer Services Team Manager,	Hywel Dda HB

	Carmarthen	
Mr Sohail Moosa	**Consultant Urologist**	**Hywel Dda HB**
Dr John Murphy	**Consultant Pathologist**	**Hywel Dda HB**
Mr Yeung Ng	**Consultant Urologist**	**Hywel Dda HB**
Dr Mau-Don Phan	**Consultant Clinical Oncologist**	**Hywel Dda HB**
Mr Ngiaw Khoon Saw	**Consultant Urologist**	**Hywel Dda HB**
Mr Mahmoud Shafii	**Consultant Urologist**	**Hywel Dda HB**
Mr Matthew Willis	**Head of Cancer Services**	**Hywel Dda HB**

Key Themes

1 Structure and Function of the Service

The peer review team met with representatives of the Hywel Dda Urological Cancers Multidisciplinary Team (MDT) to review their urological cancer services. The MDT provides services to the catchment population of Hywel Dda Health Board, a population of approximately 375,000 throughout Carmarthenshire, Ceredigion and Pembrokeshire. In addition, it also provides services to parts of Powys and the extreme south of Gwynedd.

Services are provided at all four major hospitals in the Health Board: Bronglais Hospital, Aberystwyth, Glangwili Hospital, Carmarthen; Prince Philip Hospital, Llanelli; and Withybush Hospital, Haverfordwest. Much of the health board is rural in nature, with significant distances between many of the hospitals, which can lead to challenges in providing services across a large geographic area. Although it is a single health board, many services are managed at a 'county' level in a 'three-county' structure.

The MDT do not undertake major pelvic surgery, referring these cases to the MDT at Morriston Hospital in Abertawe Bro Morgannwg UHB, but otherwise provide the whole range of diagnostic, treatment and follow up services. Glangwili Hospital been designated by the MDT as the 'Hub' for the service, providing a wider range of services than the other hospitals and managing a more complex case-mix. The main in-patient facility is at Glangwili, with short-stay and day cases being carried out at Prince Philip Hospital. There are Urologists based at Glangwili, Prince Philip and Bronglais, with services at Withybush being provided by a visiting consultant. The MDT stated that Bronglais is more self-sufficient because of its remoteness.

There is a single health board wide MDT meeting held weekly at Glangwili Hospital and all the urologists who undertake cancer work have sessions at that Hospital.

General Practitioners largely refer to their local hospital, and there are diagnostic services at all four sites. Each hospital runs a Haematuria Clinic, with three per week at Glangwili, and weekly clinics at each of the other hospitals. Referrals are sometimes passed on to another centre if there is a lack of capacity, and if waiting times are seen to be rising. This is less common for Bronglais referrals because of the distances and here patients may also be seen in the general urology clinic.

The MDT stated that in 2012 there were significant concerns over a lack of haematuria clinic capacity, but the recent funding of two new consultant posts had significantly improved matters.

There are common referral guidelines for patients with a raised Prostate-Specific Antigen (PSA) level across the health board. The way that the diagnostic services for these patients are organised varies between hospitals.

At Glangwili, there is a weekly one-stop PSA clinic, with capacity for 8 patients, where the patients see an urologist and get a Transrectal Ultra-Sound Guided (TRUS) biopsy on the same day. Patients receive their results in a separate weekly Histopathology Clinic which is run on the Urology Ward.

There is no one-stop PSA clinic at Withybush, although the MDT stated they would like to establish such a service. Currently patients will be seen in an out-patient clinic as an Urgent Suspected Cancer, usually within 10 days of receipt of referral, and referred for a TRUS biopsy. There is a weekly TRUS biopsy list, and the MDT stated there was no backlog and most patients had their biopsy within a week of the clinic.

A similar system was in operation in Prince Philip Hospital, with a weekly biopsy list, Although there was the ability to provide biopsy on the same day as the clinic, it wasn't a formal one-stop clinic. The team pointed out that the TRUS equipment needed to be replaced.

At Bronglais, the catchment population was too small to support a one-stop clinic. Patients were first seen in out-patients then listed for the next TRUS biopsy clinic which was held fortnightly.

The MDT stated that there were some problems in getting timely histology reports following biopsy. There have been significant changes in the pathology service recently, but it was still described as 'fragile' with problems in recruiting to vacant posts. It was felt that the longest turn-around time for TRUS histology could be in excess of two weeks, especially if there was a need for immunohistochemistry (IHC). It was noted that histopathology had not audited their service because of staffing shortages, however it was stated that the majority of cases were reviewed by a second pathologist.

Following diagnosis, the majority of patients had MRI staging. MRI was available at all 4 sites, but the majority was done at Prince Philip hospital because of the high quality of the scanner there. However, because of distances, Bronglais patients had their MRI locally, but the MDT was aware that the image quality was not as good because of the type of equipment there ('open' MRI).

The MDTs lead Uro-radiologist is based at Prince Phillip Hospital, and despite the fact he has no formal cover, he reviews all images prior to the MDT meeting, and interprets them for the MDT. In addition, there is a radiologist based at Bronglais with a specialist interest in uro-radiology and he links to the MDT meeting via VC to present local cases. MRIs carried out at Withybush are reviewed and presented at the MDT meeting by the lead uro-radiologist based at Prince Philip Hospital. Interventional radiology is available on all sites, but there is no formal out-of-hours service across the health board area. The MDT is currently looking at providing a urologist led nephrostomy service.

Following diagnosis and staging, all cases are discussed at the weekly MDT Meeting held at Glangwili Hospital. Any cases where radical pelvic surgery may be indicated are then referred to the regional level MDT based at Morriston; two of the Hywel Dda Urologists attend that MDT to discuss the Hywel Dda patients. The MDT is comfortable that all appropriate patients are considered for radical treatment.

All nephrectomies are now undertaken at Glangwili, and one of the Urologists has recently initiated a laparoscopic nephrectomy service.

Clinical Oncology is provided by a single handed Clinical Oncologist with a specialist interest in Urology, based at Glangwili, but with sessions at the regional Cancer Centre at Singleton Hospital, Swansea where radiotherapy is provided. Currently the oncologist has two new urology patient clinics per week and is seeing 50 new urological cancer patients per month. Because of this workload, it is impossible to see prostate cancer patients for follow-up after radical radiotherapy, and they have to be discharged for follow-up by urologists in general urology clinics. The oncologist does operate an 'open-door' policy if patients experience

post radiotherapy symptoms and will see patients referred back by the urologists urgently, however it is recognised by the MDT that this is sub-standard and that all prostate patients treated with radical radiotherapy should receive follow-up from an oncologist to monitor for any post treatment complications. Patients receive external beam radiotherapy at Singleton Hospital and Brachytherapy is available for Hywel Dda residents at Velindre Cancer Centre in Cardiff. There was a fast-track treatment planning process for prostate patients and patients usually received radiotherapy within 4 weeks of the decision to treat.

Chemotherapy for Carmarthenshire and Pembrokeshire patients is restricted to the Chemotherapy Unit at Glangwili, as there are insufficient consultant oncologist resources to oversee its provision at the chemotherapy units at Prince Philip and Withybush

Chemotherapy at Bronglais is provided by a locally based Medical Oncologist, who is not a core member of the Hywel Dda MDT. A staff grade from Bronglais attends the weekly MDT meeting. This inequity of services across Hywel Dda, together with the lack of clinical oncology resources, has been raised with the Health Board. The MDT stated that they did not feel the current service was sustainable and that there was currently no agreed plan for the development of oncology services in Hywel Dda.

Urology follow-up is undertaken at all four hospitals. There are dedicated Clinical Nurse Specialist (CNS) led follow up clinics at Withybush, Prince Phillip and Glangwili however there are insufficient CNS resources to follow up all appropriate patients and any surplus patients have to be referred to the consultant urologists for follow-up. There is a shared care policy to discharge patients back to their GP for follow-up; initially this was after 5 years, but the MDT is now moving to 2 years. The CNS's are undertaking a study looking at the acceptability of 'virtual' telephone based follow-up, alternating with clinic based follow-up appointments.

Acute Oncology has been identified as an area for development by the Health Board; however there are no identified resources. The Clinical Oncologist has been trying to take a lead and has undertaken education sessions at Glangwili, but is hampered by other clinical commitments. There has been an audit of the neutropoenic sepsis pathway, which indicated that only 16% of sepsis patients had antibiotics within one hour. New protocols have been introduced and there are plans to re-audit the service in 2014.

Following a previous peer review, all chemotherapy patients are now given a sheet with out-of-hours contact details for each hospital, usually the chemotherapy ward, but there is as yet no single out-of-hours contact number.

The Health Board has recently established an Acute Oncology Group to take forward development of the service locally.

Palliative Care is provided on a 'county' basis at each of the hospitals, although the MDT can access inpatient and community based palliative care, there are gaps in the service; there is currently only a part–time consultant in palliative care at Glangwili following a recent retirement, and no consultant at Withybush or Bronglais where the service is provided by associate specialist / staff grades.

The MDT has developed referral guidelines for suspected prostate cancer for use across the health board. Urgent Suspected Cancer (USC) referrals are very rarely down-graded but sometimes additional information has to be sought and a standards letter is used for this. Following discussion at the MDT meeting, a copy of the Canisc minutes are sent to the patients GP noting that the patient may not yet be aware of the proposed treatment plan. The MDT had not audited to see if notification of diagnosis is sent to the GP within 24 hours.

A GP forum for bladder cancer has been held and the MDT is looking at similar educational events for other cancer sites.

2 Patient Centred Care and Experience

There is a team of 2.8 wte urological cancer CNSs, based at Glangwili Hospital but also providing a service to Prince Philip and Withybush Hospitals on an out-reach basis. A nurse attends Withybush for the clinic weekly. Currently one CNS was on long term sick leave, and on the day of the peer review visit another CNS was on sick leave leaving a single CNS to run clinics, undertake intravesical treatments and provide support to patients. There is 1.0 wte general urology CNS at Bronglais, but no dedicated urology cancer resource.

Because of lack of sufficient CNS support, prostate and bladder cancer patients are prioritised but most renal patients are unable to see a CNS. The MDT believes that there should be 5.0 wte Urology Cancer CNSs across the Health Board to provide an adequate service and to support nurse-led follow-up.

The Peer Review Team noted that the lack of CNS support was reflected in the findings of the 2013 Wales Cancer Patient Experience Survey were only 68% of Hywel Dda prostate patients said they had been given the name of a CNS against a Wales average score of 80%.

It was noted that Hywel Dda has a high level of Welsh speakers, and a large proportion of patients are elderly. The MDT is unaware of whether there is any unmet need for the provision of services through the Welsh language; it has not undertaken a patient survey to ascertain the demand for such services.

a. Evidence of Key worker

Because of a lack of CNS resources and the need to cover multiple hospitals, patients are given details of CNS team rather than allocated an individual Key Worker. The MDT recognised that this was not ideal.

A review of a sample of patient case notes and Canisc electronic case notes indicated that the name of the Key Worker was not recorded. The 2013 Wales Cancer Patient Experience Survey recorded that 43% of prostate cancer patients and 33% of other urological cancer patients stated that they had been given the name of their Key Worker.

3 Service Quality and Delivery

a. MDT Service Support

There is a weekly MDT meeting very Friday afternoon at Glangwili Hospital. There is the facility to link in remotely via Video-Conferencing but all the Urologists try to attend in person. The MDT was moving to a new room the week of the Peer Review visit, which was equipped with multi-screen facilities to support video-conferencing and tele-medicine.

Co-ordinators at each hospital book their local patients onto Canisc for the MDT meeting, and the Multidisciplinary Module (MDM) is used live during the MDT meeting allowing real-time validation of clinical information. Following the MDT meeting, each ‘county’ based co-ordinator is responsible for printing out the MDT minutes/MDT decision for their patients and

filing them in the patient case-notes.

There is no palliative care membership of the MDT. There is no cover for the lead uro-radiologist.

b. Service Outcome Data

	Hywel Dda	Target
Number of USC referrals treated within 62	Prostate 134/159 (84%) Bladder 25/26 (96%) Renal 14/20 (70%)	95%
days Number of non –USC referrals treated within 32 days	Prostate 225/229 (98%) Bladder 23/27 (85%) Renal 52/60 (87%)	98%
Number of patients with Pre-treatment stage recorded	Prostate 332/422 (79%) Bladder 3/66 (4.5%) Renal 11/89 (12%)	70%
Number of patients entered into clinical trials	12 (2%)	10%
Number of patients donating to Wales Cancer Bank	0	
Number of patients discussed at MDT	Prostate 422/422 (100%) Bladder 66/66 (100%) Renal 74/78 (95%)	100%
Median time for patients with muscle invasive TCC Bladder start of definitive curative treatment	77 Days	93 Days
Median time to TURBT	Unable to provide data	

c. Key audits projects and outcomes

It was noted that there were reviews of the 'virtual follow-up' concept, but the MDT was aware that it did not have a robust local audit programme, this had been because of lack of resources, but there were now plans to develop an rolling audit programme from 2014.

d. General Observations

The Peer Review Team noted that recruitment to Clinical Trials and the Cancer Bank was low. The only Cancer Bank nurse was based at Withybush and was unable to consent patients on other sites. The Review Team suggested that the MDT discuss with the Cancer Bank alternative ways of consenting patients. The MDT reported that trials nurses were now appointed at Glangwili and Prince Philip Hospitals, and trial recruitment had now improved. It was noted that Bronglais were recruiting to a number of studies.

Data submitted by the MDT suggested that there were very low numbers of radical prostatectomies. The MDT had check the data and felt that it reflects local demographics and they were content that all appropriate patients are considered for radical treatment. It was unclear whether geography and the need to travel played any part in patient choice over the type of treatment they finally opted for. It was suggested that the MDT could audit the reasons why patients chose a particular treatment option.

It was noted that waiting times for bladder cancer were very good, but there were more problems in achieving the target for prostate cancer.

The review Team noted that there were significant differences in the pathways in use across the 4 main hospitals. There were no clear health board wide protocols and pathways.

4 Review of Clinical Information in the Clinical Notes and Canisc

The Peer Review team undertook a review of a sample of patient case notes and Canisc electronic case notes. Evidence that Notification of Diagnosis to the GP within 24 hours was found in 4/5 of the written case notes, but was not found in any of the Canisc records. Care Plans were recorded n 4/5 case notes and 1/5 of the Canisc records, and an agreed MDT Cancer Management plan was evident in 5/5 case-notes but only 3/5 Canisc Records. There was recording of the fact that a patient had seen a CNS in only 1/5 of the case-notes and in 3/5 Canisc records in the other 2/5 it was noted that the patient had not seen a CNS.

5 Engagement with Management

The Health Board had recently established a Cancer Clinical Programme Group which had input at an Executive Board Level. The MDT Lead would be a member of this group. There were suggestions that the 'county' structure of the Health Board caused additional difficulties for the MDT in taking forward developments. If there was a purely cancer issue, they could look to the Cancer Services structure for support, but in most cases it still necessitated negotiating with to three separate management structures. This could create problems when the Team were trying to develop health board-wide pathways for example. It was stated that the Health Board were reviewing their management structure

The MDT stated that they had not had input into the Health Board's Cancer Delivery Plan, but management representatives said that the new Clinical Programme group should help to address this deficit in the future.

6 Culture of the Teams

The Peer Review Team noted the significant service improvements since 2012 such as additional consultant posts, improved diagnostic clinic structures and laparoscopic surgery. The MDT demonstrated a strong team ethic and good clinical leadership and a 'can do' attitude was apparent from the whole team. The MDT was very aware of the problems that it still faced and was actively working to address them.

The Review team suggested that the MDT consider setting time aside as a team to discuss audits, service planning and development etc. The MDT stated that it does have time at the end of its weekly MDT meeting which could be used, however Pathology and Radiology cannot attend because of other commitments.

GOOD PRACTICE / SIGNIFICANT ACHIEVEMENT

- Despite significant lack of resources (see below), there was excellent support from radiology, pathology and clinical oncology to the MDT
- Establishment of a laparoscopic nephrectomy service . Although laparoscopic rates were still quite low, there were plans to increase these as the service matured. The MDT may wish to audit this service to ensure all appropriate patients have the opportunity for this treatment
- The MDT uses the MDM module 'live' in its weekly meetings
- Strong team ethic with good clinical leadership

IMMEDIATE RISKS

NONE

SERIOUS CONCERNS

- Oncology Provision – there is a single handed Oncologist for the Health Board, who is unable to provide appropriate follow-up service because of the demands of seeing all new patients. Also there is inequity in the service provided at Bronglais where the Medical Oncologist in not a core member of the MDT
- Acute Oncology – There remain significant concerns over the adequacy of the service. Although some improvements have been made following a previous Peer Review visit, agreed actions have still to be implemented e.g. provision of a single out-of-hours contact point for patients.
- CNS Provision – There is a significant shortage of Urology Cancer CNSs which could compromise the support available to patients and also means that developments such as nurse-led follow up (which would have benefits for the whole service cannot be introduced.

CONCERNS

- The fragility of the radiology service, with no cover for the uro-radiologist. It was also noted that the service at Bronglais differed from that available in the rest of the Health Board.
- Lack of written protocols and pathways.
- Lack of a robust local audit programme concentrating on urological cancer
- Palliative Care – lack of consultant led services in Withybush and Bronglais, and no palliative care membership of the MDT
- Lack of knowledge of patients' direct experience e.g. local patient surveys
- Low levels of recruitment to clinical trials and the Wales Cancer Bank