Peer Review

Cardiff and Vale University Health Board

Lung Cancer Multidisciplinary Team

MEETING ATTENDANCE

Peer Review Team

Name (Print)	Job Title	Organisation
Dr Tom Crosby	Medical Director	South Wales Cancer Network
Dr Rhian Finn	Consultant Chest Physician	Abertawe Bro Morgannwg University Health Board
Jane Hart	Lead Nurse for Cancer	Aneurin Bevan Health Board
Damian Heron	Network Director	North Wales Cancer Network
Val Jones	Lay Reviewer	Healthcare Inspectorate Wales
Sue Davies	Primary Care Development Manager	South Wales Cancer Network
Gareth Brydon	Review Lead	Healthcare Inspectorate Wales

Network Title	**South Wales Cancer Network**
Organisation Title	**Cardiff and Vale University Health Board**
Team title	**Lung Cancer Multidisciplinary Team**
Review Date Title	**19 March 2013**

Name (Print)	Job Title	Organisation
Dr Diane Parry	Consultant Respiratory Physician / MDT Lead	Cardiff and Vale UHB
Dr Richard Attanoos	Consultant Pathologist	Cardiff and Vale UHB
Dr Anthony Byrne	Consultant in Palliative Medicine	Cardiff and Vale UHB
Dr Emma Hudson	Consultant Oncologist	Velindre NHS Trust
Heather Hyatt	Research Nurse	Wales Cancer Bank
Ceri Jones	Service Improvement	Cardiff and Vale UHB
Alison Kelly	Research Nurse	Wales Cancer Research Network
Dr Jason Lester	Consultant Oncologist	Velindre NHS Trust
Susan Newton	Lung Cancer CNS	Cardiff and Vale UHB

Dr Annie Procter	Lead Cancer Clinician	Cardiff and Vale UHB
Tamsin Rees	Lung Cancer Co-ordinator	Cardiff and Vale UHB
Kay Rowe	Lung Cancer CNS	Cardiff and Vale UHB
Natalie Taylor	Mesothelioma / Surgery Co-ordinator	Cardiff and Vale UHB

Key Themes

With reference to guidance on Key Themes in the evidence guides, please provide comments including details of strengths, areas for development and overall effectiveness of the team. Any specific issues of concern or good practice should also be noted in the following sections.

1. Structure and Function of the Service

The Peer Review team met with members of the Cardiff and Vale University Health Board Lung Cancer Multidisciplinary Team (MDT) on 19th March 2013. Respiratory medicine within the health board is based at the two main hospitals; University Hospital for Wales and University Hospital Llandough. The Cardiff and Vale Lung Cancer MDT is based at University Hospital Llandough and has close working relationship with colleagues based in University Hospital of Wales, ensuring robust referral pathways which support good patient flow.

The team have developed an operational policy which describes their service; they hold regular business meetings to ensure the service is aligned with best practice guidelines.

Number of new patients reviewed by the MDT in 2011: 259.

The Lung Cancer Lead Clinician has developed close links with Primary Care colleagues and presents at their 'Protected Time for Learning' events as an opportunity to update General Practice on the signs, symptoms and referral criteria of Lung Cancer and together are developing a Lung Cancer e-learning module on the signs and symptoms of Lung Cancer.

Whilst early diagnosis is supported by an "open access" chest X-ray service for Primary Care, abnormal chest x-rays are routinely reported directly back to the referring general practitioner. The Lung Cancer team stated that they have had numerous discussions with the radiology management team to set up a 'flagging' system for abnormal chest x-rays to be sent to the Lung Cancer MDT Co-ordinator. However, this process has not been formally adopted across radiology, which may adversely impact on the patient pathway and achievement of cancer waiting time targets.

The lung cancer team confirmed that they have timely access to all diagnostic techniques e.g EBUS, PET and EGFR and this is reflected in their achievement of the cancer waiting times.

An excellent pleural service has been developed and Cardiff and Vale UHB hosts the South East Wales Endobronchial Ultra Sound (EBUS) Service, which supports prompt diagnosis and staging which is evident by the teams' time to diagnosis. The team has developed close working relationships with lung cancer teams across the network, ensuring good communication. Medical thoracoscopy is currently performed by the thoracic surgical service; however the lung cancer team confirmed that they have secured funding to purchase the equipment needed to undertake medical thoracoscopy.

Oncology services are provided by Velindre Hospital and thoracic surgery by the Cardiff and Vale Health Board. The MDT highlighted difficulties in securing

attendance of all core members at the MDM, particularly thoracic surgery, because of the lack of cover for that role. The Lung Cancer Lead Clinician stated that this had been escalated to the Health Board, WHSCC and the South Wales Cancer Network. The Review Team expressed their concern with the apparent lack of engagement from senior management within the health board in addressing this issue. There was concern that the lack of thoracic surgical cover may result in patient delays in receiving potentially curative treatment.

The Review Team noted the low NSCLC resection rate (see Section 3b) but were unable to further pursue this discussion as the thoracic surgeon was unable to be present at the peer review meeting.

Patients receiving chemotherapy for their Lung Cancer are treated at University Hospital of Wales, Llandough. However, there is no oncology presence or Acute Oncology Service available at Llandough Hospital and the oncology team are dependent on the Lung Cancer Nurse Specialists as the point of contact for patients who may have complications due to chemotherapy (and the respiratory ward out of hours). This service has become weakened by the Lung Cancer Nurse Specialists having to return to the ward one day a week.

2. Patient Centred Care and Experience

There was no evidence of recent surveying of lung cancer patients to gain their views of the service. A network-wide lung cancer patient satisfaction survey was undertaken in 2010; however numbers were very small. The lung cancer nurses currently have an on-going survey to gain the patients' views of the service and to date they have received 40 responses. However, there was no clear indication that patients were given the opportunity to systematically feedback on the service they had received.

The service is well supported by specialist palliative care and holistic needs assessments are undertaken using the SPARC assessment tool.

a. Evidence of Key worker

There are 4 named lung cancer specialist nurses in Cardiff and Vale. Whilst this seemed like an excellent level of service, unusually, they are also involved in giving patients their chemotherapy and they were being asked to work on the general wards for one day per week. The team have developed a comprehensive range of services, which compliment the lung cancer service and enhance the patient experience. These include a breathlessness clinic based on the INSPIRE model and a nurse-led intervention clinic. The team are planning to further enhance the service by providing a nurse led follow up service. In addition, members of the nurse team will be undertaking a nurse prescribing course. It was felt that there was huge scope to increase specialist roles, such as non medical prescribing, requesting of radiological investigations and nurse led clinics. In addition, they could contribute to the development of acute oncology services across the LHB.

Working closely with patients the Lung Cancer Nursing team have created a patient story; a powerful model to understand the patients' experience of their care. The team have been invited to present their work at a National Lung Cancer Conference.

Review of the medical notes failed to provide evidence of clear documentation of the named "Key Worker" for the patient.

The support for patients who have undergone chemotherapy was not clear. Whilst patients are told to contact the lung ward out of hours, it was not clear how it was ensured that this call was received by someone aware of the treatment the patient had received or its likely toxicities.

3. Service Quality and Delivery

a. MDT Service Support

Histopathology cover is provided at specialist registrar level, noting that the department is not recruiting new staff when members of the team retire. The Head of Service has asked that pathologists do not attend cancer MDT meetings to highlight the shortage of cover and help to facilitate the recruitment of histopathologists.

b. Service Outcome Data

Collated responses For the Information Section of Peer review Key: X - No data provided	Met Target **C&V - Llandough**	**National Target**	**Best LHB Wales**
Number of Non-small Cell Lung Cancer (NSCLC) patients having a resection.	13/142 (9%)	14%	**HD- WGH 22%**
Number of USC referrals treated within 62 days.	79/84 (94%)	95%	**BCU- 98%**
Number of non-USC referrals treated within 31 days.	147/147 (100%)	98%	**BCU- YG, BCU YMW, C&V, HD-BGH, HD-GGH 100%**
Number of patient with pre-treatment stage recorded.	248/259 (96%)	85%	**CT-RGH, HD-BGH, HD-GGH 100%**
Histological / cytological confirmation rate.	184/259 (71%)	75%	**ABMU-NPT 83%**
Number of patients receiving active treatment for lung cancer.	132 (51%)	60%	**HD-WGH 77%**
Number of small cell lung cancer patients receiving chemotherapy at any stage.	22/28 (78.5%)	65%	**HD-BGH 100%**
Number of small cell lung cancer patients receiving treatment within 14 days of diagnosis.	11/28 (39%)	100%	**ABMU - NPT 86%**
Number seen by specialist nurse at diagnosis.	247/259 (95%)	100%	
Percentage of patients with 30 day post treatment mortality for:			
a) Chemotherapy;	Wrong data submitted		
b) Surgery.	0%		
Number of patients entered into clinical trials.	18/259 (7%)	10%	

Number of patients donating tissue to the Wales Cancer Bank.	12/259 (5%)	20% by 2016	

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

Active treatment rates (surgery, chemotherapy and radiotherapy) for Non Small Cell Lung Cancer (NSCLC) were significantly lower than the Wales mean.

% of patients with histologically confirmed NSCLC who received a PET Scan was reported as below the Welsh average.

The National Lung Cancer Audit 2012 reported resection rates for NSCLC as more than 3 deviations from the Welsh mean.

d. Key audits projects and outcomes

Numerous examples of audits and reviews were submitted, although it would have been helpful to understand what lessons had been learned from these and how the service had changed as a consequence.

e. General Observations

In terms of preparation for the Peer Review, concerns were expressed about the internal assessment process and the lack of managerial leadership and engagement. The lack of leadership has resulted in the submission of poor quality and inaccurate information to support the internal assessment process. As a result, the peer review team were unable to gain a full picture of the service provided by the Cardiff and Vale Lung Cancer Team.

The pathologist stated that there was inadequate cover for pathology. Indeed pathologists in Cardiff and Vale were told that they should be seen to 'fail cancer standards' to highlight the lack of funding for this service.

Radiology and thoracic surgery were not present at the review, which is likely to represent inadequate support, at least in terms of cover, for these disciplines.

The issue of acute oncology support in general in Cardiff and Vale UHB and the particular issue for out of hours support for chemotherapy patients requires further exploration. The reported 30 day mortality of 40% post chemotherapy was obviously an error but did raise the issue of lack of wider clinical engagement in verifying the data.

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

From the patient medical records seen at the review, the peer review team were impressed at the comprehensive MDT discussion reports available in the patients' records.

5. Engagement with Management

The Clinical Lead for Cancer was present at the Review, as was the Service Improvement Management from Cancer Services, but there were clear issues in terms of lack of engagement with the information made available for both self assessment and the peer review visit. Whilst all the site specific leads attend a regular cancer Services meeting, it was unclear how issues such as the need for greater surgical services, direct referrals from radiology and acute oncology support were escalated to the Executive Board. This lack of managerial and administrative support for the process was a serious concern.

6. Culture of the Teams

There is no doubt that the Cardiff MDT demonstrates many strengths, including the engagement of clinical leads across the lung cancer disciplines. They provide many tertiary services including a tertiary service for patients with mesothelioma and a regional EBUS service, as well as leading in many clinical trials. However, it is clear that there is a lack of managerial support for the team, both in terms of preparation for this review, and support for key issues such as provision of adequate surgical services. In the absence of this, the clinical lead has done her best to provide the required information for this review, but could have better involved other members of the team.

GOOD PRACTICE

Identify any areas of good practice

Good Practice/Significant Achievements:

- Engagement with Primary Care and the development of an e-learning module
- Excellent pleural service
- EBUS Service
- Excellent time to diagnosis and treatment
- Lung Cancer Clinic Nurse Specialists nurse led follow up clinic and management of breathlessness support
- Patient Stories

CONCERNS

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

- Data Quality
- Lack of adequate thoracic surgical support for MDM
- Lack of organised Acute Oncology Service within the Health Board with concern as to the arrangement for dealing with acute complications of chemotherapy out of hours

SERIOUS CONCERNS

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

- Lack of Management Support and Leadership throughout the Peer Review process

IMMEDIATE RISKS

These should be brought to the attention of the team and a response from the LHB regarding its plans to remedy these concerns should be made within 1 week

NONE

Glossary : Lung Cancer Peer Review

C&V UHB	Cardiff & Vale University Health Board .
Bronchoscopy	This is a technique of visualizing the inside of the airways for diagnostic and therapeutic purposes. An instrument (bronchoscope) is inserted into the airways, usually through the nose or mouth, or occasionally through a tracheostomy. This allows the practitioner to examine the patient's airways for abnormalities such as foreign bodies, bleeding, tumours, or inflammation. Specimens may be taken from inside the lungs. The construction of bronchoscopes ranges from rigid metal tubes with attached lighting devices to flexible optical fiber instruments with realtime video equipment.
CHART (Continuous Hyper Fractionated Accelerated Radiotherapy)	Hyperfractionated means giving more than one treatment (fraction) of radiotherapy per day. One type of hyperfractionated radiotherapy is called CHART. It stands for Continuous Hyperfractionated Accelerated Radiotherapy. The whole dose of radiation is about the same that would be applied for cancer with standard radiotherapy. The difference is that treatment is administered every day over 12 days instead of over several weeks. It requires a stay in hospital because as many as 3 treatments are administered every day.
CNS	Clinical Nurse Specialist.
CT (Computerised Tomography)	X-ray computed tomography, also computed tomography (CT scan) or computed axial tomography (CAT scan), is a medical imaging procedure that utilizes computer-processed X-rays to produce tomographic images or 'slices' of specific areas of the body. These cross-sectional images are used for diagnostic and therapeutic purposes in various medical disciplines.
CXR	Chest x-ray
DGH	District General Hospital.
EBUS (Endobronchial	An endobronchial ultrasound (EBUS) is a procedure that may be performed during a bronchoscopy, to

Ultrasound)	provide further information to diagnose or determine the stage of a lung cancer. This relatively new technique allows viewing of regions of the lungs and surrounding chest area that have traditionally required more invasive surgical procedures to evaluate.
GP	A General Practitioner.
HIW	Healthcare Inspectorate Wales.
IMRT (Intensity Modulated Radiotherapy)	This is an advanced mode of high-precision radiotherapy that uses computer-controlled linear accelerators to deliver precise radiation doses to a malignant tumour or specific areas within the tumour. IMRT allows for the radiation dose to conform more precisely to the three-dimensional (3-D) shape of the tumour by modulating—or controlling—the intensity of the radiation beam in multiple small volumes. IMRT also allows higher radiation doses to be focused to regions within the tumour while minimizing the dose to surrounding normal critical structures.
LHB	Local Health Board.
MDM (Multi Disciplinary Meeting)	A meeting made up of a variety of expert health care professionals.
MDT (Multi Disciplinary Team)	Multi-disciplinary teams (MDTs) are made up of expert health care professionals who have specialised knowledge and training in specific cancers. The teams meet regularly to discuss individual cases and to plan the best course of treatment for the patient. MDTs improve communication and decision making, waiting times and patient care.
NSCLC (Non Small Cell Lung Carcinoma)	NSCLC is any type of epithelial lung cancer other than small cell lung carcinoma (SCLC). As a class, NSCLCs are relatively insensitive to chemotherapy, compared to small cell carcinoma. When possible, they are primarily treated by surgical resection with curative intent, although chemotherapy is increasingly being used both pre-operatively (neoadjuvant chemotherapy) and post-operatively (adjuvant chemotherapy). The most common types of NSCLC are squamous cell carcinoma, large cell carcinoma, and adenocarcinoma, but there are several other types that occur less

	frequently, and all types can occur in unusual histologic variants and as mixed cell-type combinations.
PET (Positron Emission Tomography)	PET is a nuclear medical imaging technique that produces a three-dimensional image or picture of functional processes in the body. The system detects pairs of gamma rays emitted indirectly by a positron-emitting radionuclide (tracer), which is introduced into the body on a biologically active molecule. Three-dimensional images of tracer concentration within the body are then constructed by computer analysis. In modern scanners, three dimensional imaging is often accomplished with the aid of a CT X-ray scan performed on the patient during the same session, in the same machine.
RT (Radiotherapy Treatment)	Radiotherapy Treatment is the use of high energy x-rays and similar rays (such as electrons) to treat cancer.
SBRT (Stereotactic Body Radiation Therapy)	Stereotactic body radiation therapy (SBRT) is a technique that utilizes precisely targeted radiation to a tumour while minimizing radiation to adjacent normal tissue. This targeting allows treatment of small- or moderate-sized tumours in either a single or limited number of dose fractions.
VC	Video Conference facilities.