Action Plan following Lung Peer Review Process
July 2013

Peer Review Statement	Required Action	By whom	By when
Whilst both have business meetings to audit and reflect on the processes and outcomes of the service, it was not clear in respect of the Royal Glamorgan MDT whether all members had been invited or attended these meetings.	Both MDts to organise quarterly business meetings as a minimum and to ensure all MDT members are invited and records are kept.	Cancer Leads, Royal Glamorgan Hospital and Prince Charles Hospital.	Commence immediately.
Both teams recognised late presentation of lung cancer patients as the key challenge and hoped the links with Primary Care would be improved through the Macmillan GP Facilitator project and help address this in the future.	Macmillan GP Facilitator focused on End of Life so this project would not address late presentation issues. To engage with local public health team. Meeting to be set up to develop a plan for this. National awareness campaign ongoing. Plan a local awareness campaign as part of Communication Cancer Awareness Network (CCAN).	CCAN – October 2013 when next campaign due. Public Health Involvement	Commence October 2013 and ongoing.
The Royal Glamorgan MDT holds a meeting for radiology, respiratory medicine and thoracic surgery first thing on a Tuesday morning. There is then a further meeting with oncology, respiratory medicine, pathology and radiology at lunchtime. Therefore the surgical and oncology teams are never in the same meeting. Whilst communication was said to be good within the team, it was not clear how these communications were formally documented in case notes and information systems.	Ensure all communication are formally documented in patient notes and on Canisc. Aim to improve record keeping. Reorganise Royal Glamorgan MDM to single meeting which includes oncology and thoracic surgery.	Cancer Lead Cancer Lead Clinician, Cancer Lead – Royal Glamorgan Hospital.	Commence immediately December 2013

Some delays have been encountered with the Endobronchial Ultra Sound (EBUS) service provided by Cardiff & Vale LHB. However, the Royal Glamorgan team said this had improved recently whilst Prince Charles explained there could be up to a 4 week delay. Both teams expressed a willingness to see their own EBUS service developed and provided within the Health Board but it was felt that this was unlikely to be funded. There are plans to develop a medical thoracoscopy service in PCH within the next year.	Issues across Wales regarding provision of EBUS. Continue to work across the Network to find South Wales Solution as this is not economically feasible for the health board to provide this service. Audit time for EBUS and EUS from request to examination and time to final cytology/histology report.	Cancer Lead Clinician Cancer Leads Prince Charles and Royal Glamorgan Hospitals Cancer Leads Prince Charles and Royal Glamorgan Hospital	 January 2014
Thoracic surgery is provided by Cardiff and Vale Health Board and Clinical Oncology by Velindre NHS Trust. There were issues raised with regard to the adequacy of support for both these service across the Health Board. Despite this, the surgical resection rate in Royal Glamorgan Hospital is very good.	The lack of thoracic surgical input and Oncology cover has been raised at Board level and with the relevant neighbouring Health Boards. Board to continue to liaise with colleagues in Cardiff and Vales to improve the service for patients of Cwm Taf. Thoracic surgical support to CTHB is excellent although formal cross cover arrangements need to be established. Reorganise Royal Glamorgan MDM to single meeting which includes oncology and thoracic surgery. Improve clinical oncology support and MDM attendance at RGH	Cancer Lead Clinician, CVUHB Cancer Lead Clinician Cancer Lead Royal Glamorgan Hospital CVUHB, Velindre NHS Trust Cancer Lead Clinician Cancer Lead Royal Glamorgan Hospital Velindre NHS Trust	 December 2013 December 2013 December 2013

In Royal Glamorgan, the nurse was unable to see all patients at the point of delivering diagnosis and bad news due to supporting up to 3 doctors in one clinic, although all patients were contacted very soon afterwards. The nurse led follow up clinic had been a positive development. It was stated that work commitments limited annual leave.	In 2011 91% of patient at Royal Glamorgan Hospital was seen by a CNS (National Lung Cancer Audit Report 2012). Review the patient pathway with the Lung CNS. The Lead Cancer Nurse will review timetables and work commitments of CNSs and explore options for cross cover.	Lead Clinician Royal Glamorgan Hospital Lead Cancer Nurse	October 2013 October 2013
The number of patients with small cell lung cancer receiving chemotherapy (53%) was below the national target in Royal Glamorgan. The Review Team also noted that only 6% of small cell lung cancer patients at Royal Glamorgan received treatment within 14 days of diagnosis and that the Wales Lung Cancer Data Report 2012 also highlighted the percentage of patients receiving chemotherapy within 10 days of the decision to treat (see Section 3c). The Team felt this may be a result of the patient pathway. It was noted that In Prince Charles Hospital, the specialist nurse coordinated appointments for the oncologist."	Following formal review of the All Wales Lung Cancer Audit patient pathways have been streamlined and subject to on-going audit.	Royal Glamorgan Multi Disciplinary Team	Commenced June 2013
The use of Canisc and the Multidisciplinary Module (MDM) module at Prince Charles has been seen to be very beneficial allowing all information to be in one place at any given time when making decisions. The team at the Royal Glamorgan Hospital are not currently using the MDM module	A review of the functioning of the Cancer Services Team has commenced. An additional member of staff has been allocated to the RGH team to assist with the growing workload. This member of staff is currently undergoing training. The team to work towards the adoption of the MDM module.	Lead Clinicians Royal Glamorgan and Prince Charles Hospitals	December 2013
Patient Centred Care and Experience			
The Health Board participated in the 2010 S E	Continue regular patient surveys.	Lead Clinicians Royal	Ongoing.

Wales Network Lung Cancer Survey, and in 2012 carried out its own Survey across both Teams, with 21 patients responding. Both teams said there was intent to carry out further surveys. Analysis of patient complaints and performance measures could also be used to assess if Cwm Taf Health Board was providing appropriate service to patients with lung cancer.	Plan to analysis patient complaints and performance measures.	Glamorgan and Prince Charles Hospitals	
Although CNSs in both teams see most of their patients during the pathway, (well above the national target), the Royal Glamorgan CNS was not always able to be present at the point of breaking bad news due to lack of CNS resource to support all consultants clinics.	As noted in section 1.		October 2013
The review team noted that the PCH CNS was able to provide a wider range of clinical practices than the CNS at Royal Glamorgan; This included non medical prescribing and radiology ordering. It was noted that the CNS in RGH was relatively new in post compared to the more experienced CNS at Prince Charles.	CNS at RGH to apply to become 'adopted' by Macmillan. One benefit of this will be to access funding so that the Nurse Prescribing course could be undertaken and the annual training bursary would ensure the development of this CNS to undertake a similar role to that provided at PCH. A nurse led follow up clinic was established in June 2012 in Royal Glamorgan Hospital.	June 2013 - Lead Cancer Nurse approved the CNS prescribing training. July 2013 - adoption application submitted to Macmillan.	
Review of the sample of case notes showed evidence of a Key Worker being allocated to each patient. This was documented in most of the patient notes and on Canisc for each of the case notes reviewed.	Continue practice of ensuring allocated key worker is documented in all patients case notes and Canisc. New proforma introduced in Prince Charles Hospital to ensure compliance.	Cancer Lead, Prince Charles Hospital Cancer Lead, Royal Glamorgan Hospital	
Service Quality and Delivery			
The majority of core multidisciplinary team members are in place with the exception of:	CTHB to work both internally and with CVUHB and Velindre NHS Trust to further improve MDM	Executive Lead for Cancer	Demonstrated improvement by

Royal Glamorgan Hospital – No thoracic surgical input to the main MDT meeting plus no cross cover. The oncology consultant was often not present or arrived late to MDT meetings because of overrunning clinics immediately prior to the meeting, also there was no cross-cover. The palliative care consultant attends every other meeting plus no cross-cover. There is no cross-cover for lung cancer CNS. Prince Charles Hospital - Thoracic surgery input is variable plus no cross-cover. There is no cross cover for lung cancer CNS or oncology consultant. There could not be any cross-cover between MDTs as the MDT meeting times were different. Although there was no surgical input to the Royal Glamorgan Hospital MDT meeting, attempts are made to overcome this, through other communication channels.	attendance. Reorganise Royal Glamorgan MDM to single meeting which includes oncology and thoracic surgery. Thoracic surgical support to CTHB is excellent although formal cross cover arrangements need to be established. The Lead Cancer Nurse will review timetables and work commitments of CNSs and explore options for cross cover. There are now 2 WTE thoracic surgeons providing a service for South Wales work is ongoing to ensure surgical presence at RGH MDT. But even when that is completed there will be no cross cover for annual/study leave. Also require greater oncology input for Cwm Taf patients as there is still no cover for annual/study leave. Need to progress in addressing the lack of CNS cover.	Cancer Lead Clinician Cancer Leads at both sites Lead Nurse for Cancer	December 2013
Service Data Outcomes			
Unmet targets PCH: - Number of Non-small cell lung cancer patients having a resection (13.5%, national target 14%)	The data that is quoted within this section although stated from the Wales Lung Cancer Data Report 2012 is actually the result of data collected between 2009 and 2010 and is not an accurate representation of the current service. The National Lung Cancer Audit (NLCA) published 2011 data.		

- Number of USC referrals treated within 62 days - Number of non USC referrals treated within 31 days.	NLCA resection rate 14% (Wales total 11%) - A revised escalation process is being put in place in an attempt to improve performance. This will include enhanced weekly monitoring and a more robust information exchange with tertiary centres.		
- Histological/cytological confirmation rate (71% achieved. National target 75%)	- MDTs to strive to obtain histological/cytological proof if it is in the patients best interest. Audit data reported and target is irrespective of performance status or treatment options. - Reviews of patients who have not had tissue diagnosis have been undertaken and these show that they are predominately performance stage 3 or 4 and therefore not fit for therapy and therefore tissue diagnosis won't alter treatment, shouldn't be carried out or have had radiotherapy without tissue. No action required.		
- Number seen by specialist nurse at diagnosis (99%. Target 100%)	- - As in section 1 above.		
- - Number of patients entered into clinical trials (2%, target 10%).	- R & D department to get ratification of the R & D Strategy and Delivery Plan 2013 – 2016. - Commence the pathway to recruit Research Nurse to support research active professionals across Cwm Taf Health Board. - To continue to support Cancer related research studies involving Cwm Taf Patients.		
- Number of patients donating tissue to the Wales Cancer Bank (0, target 20%	- As part of the new SMP which works alongside the Welsh Cancer Bank pathways being developed to ensure samples can be donated to Welsh tissue		

by 2016).	Bank. This will help ensure out patients have access to the next generation of targeted therapies.		
Unmet targets RGH: - Number of USC referrals treated within 62 days (91%, target 95%) - Number of small cell lug cancer patients receiving chemotherapy at any stage (53%, target 65%) - Number of small cell lung cancer patients receiving treatment within 14 days of diagnosis (6%, target 100%). - Number seen by specialist nurse at diagnosis (80%, target 100%) - Number entered into clinical trials (0, target 10%). - Number of patients donating tissue to the Wales Cancer Bank (0, 20% by 2016)	- as above. - Non compliance highlighted to clinical oncologist and current practice being reviewed. - Following formal review of the All Wales Lung Cancer Audit patient pathways have been streamlined and subject to ongoing audit. - As above. - As above - As above.	Cancer Lead, Clinical Oncologist RGH MDT	Commenced June 2013
Wales Lung Cancer Data Report 2012			
The CT-PET rates at the Royal Glamorgan were significantly higher than the Wales average. An audit of whether patients were fit for active therapy following PET had not been carried out to validate the appropriateness of referrals.	To undertake an audit of appropriateness of referrals.	Cancer Lead, Royal Glamorgan Hospital	
Resection rates for all non small cell lung cancer (NSCLC) patients at Prince Charles hospital were more than 3 Standard deviations below the Wales mean	Unfortunately the data commented on by the peer review team is three years old and therefore not an accurate reflection of the current service offered at PCH the most up to date validated UK wised data which the peer review team chose not to examine shows that the surgical rate in Prince Charles has raised from 5% to between 13% and 14% of	No further action required as current data reflect good level of compliance.	

	patients in the last 2 years. The all Wales mean for that period of time was 11%. However we always strive to improve our service and are currently conducting an audit of those patients with early stage disease with performance status 1 or 2 who didn't have surgery to examine reasons behind this to see if this is a pathway issue or co-morbidity issue.		
Chemotherapy rates for all NSCLC patients and for those with Stage 3 & 4 NSCLC at Prince Charles were low in comparison with the Wales mean	The data commented on by the peer review team is three years old. Data from the 2012 LUCADA report shows that at PCH 70.8% of patients with a performance status of 0-1 NSCLC and similarly 91.7% of patients with SCLC received chemotherapy –rates far above the Welsh and UK average.	No further action required as 2012 Lucada data shows rates far above the Welsh and UK average.	
The percentage of patients with small cell lung cancer (SCLC) patients commencing chemotherapy within 10 days of the decision to treat at Royal Glamorgan was relatively poor in comparison with the best performing MDTs in Wales.	See notes above (section 1).		
d. General Observations			
The peer review team were told of a survey of the lung cancer pathology NOS rates which had been surprisingly high. It was concluded that this was the result of reporting incomplete data that had been entered in to Canisc. This was an example of where data had not been examined sufficiently, prior to clinical sign off for a National audit/review process.	Increased core biopsy rates at RGH now established. Canisc data updated when immunohistochemistry results available. NOS rates at RGH expected to decrease to all Wales Mean.	MDT RGH	Ongoing

Surgical resection rates for the RGH team are higher than average and compared with the PCH. It is possible that a review of the diagnostic and management pathways may improve these figures further. The lower resection rates in PCH were felt to relate to a different patient population and late presentation.	As stated above Lucada Data shows high resection rates for PCH and RGH. See answer above.	No further action required.	
Review of a sample of case notes showed evidence of a Key Worker being allocated to each patient. Notification of the GP being informed of diagnosis within 24hrs was not so clear. The Review team understands that an MDT letter is generated after the MDT and faxed to the GP, but couldn't find evidence of the fax being sent in all cases in the review of a sample of notes. They were unable to find evidence in Canisc. All other items were present.	PCH team strongly contest the point made in there that documentation of the GP being informed of the diagnosis within 24 hours was not clear. Having now looked at the notes applied to the peer review group it was clear that in each set of those notes was a green MDT letter generated after the MDT and faxed to the patient's GP within 2 hours of the MDT session. Currently the fax confirmation is kept with a copy of the letter but will now be secured in the patient notes. RGH team to continue current process but improve record keeping.	Cancer Lead RGH/PCH	
The management structure within Cwm Taf Health Board and communication between departments had consequently changed in the previous 12 months. This is evident through the change in membership of the Strategy and Steering Groups. It was not clear that the issue of lack of support from thoracic surgical services had been escalated to the Health Board level.	Cwm Taf Health Board responded to this report to the Network with a list of dates of Board papers detailing the lack of thoracic surgical input at the MDM. Again this is included in the 2013 Board paper outlining areas of non compliance to the Cwm Taf Health Board. Both teams felt they wanted to make a very clear statement of how impressed and supportive they are of the current thoracic surgeon's commitment to the MDDT and that any issues picked up as a result of the peer review process are down to her having to	No further action required. Action required by Cardiff and Vale.	

	run an essentially single handed service for the whole of South Wales currently. Greater SWCN thoracic surgical support required.		
There appears to be good team working within both MDTs but this is not necessarily the case across the Health Board. There is no evidence of standardisation of protocols, pathways and practices across the whole Health Board.	Both MDTs function separately with some cross cover of pathologists and radiologists. Both teams to work together with a view to standardisations of protocols, pathways and practices, facilitated by the Lead Clinician. All Wales Lung Cancer Audits 2011 resulted in joint MDT benchmarking meeting and action plan.	Lead Clinicians	Ongoing
Job plans for the Lead Clinicians appear to differ greatly. The lead at Royal Glamorgan reported a difference of opinion with management over the adequacy of time being allocated to leading and delivering the lung cancer service. The Prince Charles lead has time in his job plan to allow for administration and audit etc and this appeared to be reflected in the data supplied to the review team.	Job plan/roles to be reviewed to ensure consistency.	Cancer Lead Clinician/Executive Lead.	
A feeling of ownership of the data and the service permeated through all Prince Charles team members. This was not the same within the Royal Glamorgan team, who submitted many documents	Regular 'MDT business meetings' would allow for more protected time to review data and audit findings.	Lead Clinician.	Plan meetings August 2013
Both teams had held, and plan to increase the number of business meetings for the MDTs. The team at PCH aim to hold them on alternate months.	Teams to plan their regularly business meetings.	Lead Clinicians.	August 2013
The Royal Glamorgan team suffered from what appeared to be a disjointed patient pathway.	RGH Team to review current working arrangements of the MDT.	Cancer Lead Clinician/Cancer	August 2013

Although good interpersonal communications appear to make this pathway work, the ad hoc emails and conversations required are not recorded. Additionally, holding 2 meetings on a Tuesday morning, one with surgery and some members of the MDT, prior to the main MDT meant there was no opportunity to have direct surgical/oncological interaction	The communication with Oncology and Surgery via emails and telephone conversations outside the MDM is usually recorded in the referral letter to the specialist teams and uploaded on Canisc.	Lead RGH	
Both MDTs had a designated lead clinician and good working relationships within the team. Communication appears to be a strong point between each of the teams although many patient discussions within the RGH team were not recorded as they occurred in a less formal and coordinated fashion.	Ensure all communication are formally documented in patients notes on Canisc. Reorganise Royal Glamorgan MDM to single meeting which includes oncology and thoracic surgery.	Cancer Lead, Royal Glamorgan Hospital. Cancer Lead Clinician, Cancer Lead RGH, CVUHB, Velindre NHS Trust.	Commence immediately. December 2013

Areas of concern

- Surgical attendance at both MDT meetings
- Lack of cover at MDTs for disciplines including thoracic surgery, oncology and lung cancer CNS
- Lack of clinical leadership and coordination in the Royal Glamorgan MDT although this may be as a result of the lack of dedicated time in job plans for lung cancer and for clinical leadership of the MDT.

Areas of serious concerns

- None.

Immediate Risks Identified

- None