Head & Neck Cancer Peer Review

Betsi Cadwaladr University Health Board

Ysbyty Glan Clwyd, Ysbyty Gwynedd & Wrexham Maelor Hospital

MEETING ATTENDANCE

Peer Review Team

Name	Job Title	Organisation
Tom Crosby (Chair)	Medical Director	South Wales Cancer Network
Sandeep Berry	Consultant ENT Surgeon	Cwm Taf ULHB
Bill Brereton	Lay Reviewer	Health Inspectorate Wales
Mererid Evans	Consultant Clinical Oncologist	Velindre NHS Trust
Mike Fardy	Consultant Oral & Maxillofacial Surgeon	Cardiff & Vale UHB
Les Hammond	Assistant General Manager-Cancer Services	Abertawe Bro Morgannwg UHB
Sian Lewis	Dietitian	Velindre NHS Trust
Rhian Rhys	Consultant Radiologist	Cwm Taf ULHB
Jane Wall	Macmillan Head & Neck CNS	Cwm Taf ULHB
Hywel Morgan	Network Director / Visit Facilitator	South Wales Cancer Network

Network Title	**South Wales Cancer Network**	
Organisation Title	**Betsi Cadwaladr University Health Board**	
Team title	**Head & Neck MDT**	
Review Date Title	**26.9.14**	
Name	**Job Title**	**Organisation**
Nicholas Archard	Consultant Radiologist	Betsi Cadwaladr UHB (YC)
Mark Atkinson	Consultant Pathologist	Betsi Cadwaladr UHB (YGC)
Sian Baldock	MDT Co-ordinator	Betsi Cadwaladr UHB (WMH)
Alagar Chandra-Mohan	Consultant ENT Surgeon	Betsi Cadwaladr UHB (WMH)

Mark Cooke	Head & Neck Nurse Specialist	Betsi Cadwaladr UHB (YG)
Leah Cox	Therapeutic Radiographer	Betsi Cadwaladr UHB (YGC)
Marion Gash	Dietitian	Betsi Cadwaladr UHB (YGC)
Simon Gollins	Consultant Clinical Oncologist & Lead Clinician, Head & Neck Cancers	Betsi Cadwaladr UHB (YGC)
Damian Heron	Associate Chief of Staff – Operations & Planning, Cancer Services & Director, North Wales Cancer Network	Betsi Cadwaladr UHB
David Hill	Consultant ENT Surgeon	Betsi Cadwaladr UHB (YG)
Huw Jones	Consultant Oral & Maxillofacial Surgeon	Betsi Cadwaladr UHB (YGC)
Katie Jones	MDT Co-ordinator	Betsi Cadwaladr UHB (YGC)
Sue Kirk	Speech & Language Therapist	Betsi Cadwaladr UHB (WMH)
Dawn Leoni	Speech & Language Therapist	Betsi Cadwaladr UHB (YG)
Chris Lloyd,	Consultant Oral & Maxillofacial Surgeon	Betsi Cadwaladr UHB (YGC)
Senthil Muthu	Consultant Radiologist	Betsi Cadwaladr UHB(WMH)
Rekha Neupane	Consultant Clinical Oncologist	Betsi Cadwaladr UHB (YGC)
Tom Nisbet	Consultant in Restorative Dentistry	Betsi Cadwaladr UHB (WMH)
Chris Penfold	Consultant Oral & Maxillofacial Surgeon	Betsi Cadwaladr UHB (YGC)
Karen Prevc	Directorate General Manager, Surgery	Betsi Cadwaladr UHB (WMH)
Vishwanath Puranik	Associate Specialist in ENT Surgery	Betsi Cadwaladr UHB (YG)
Hattie Rees	MDT Co-ordinator	Betsi Cadwaladr UHB (YG)
Gwen Roberts	Head & Neck Nurse Specialist	Betsi Cadwaladr UHB (YGC)
Liz Thomas	Speech & Language Therapist	Betsi Cadwaladr UHB (YGC)
David Widdowson	Consultant Radiologist	Betsi Cadwaladr UHB (YGC)
Hisham Zeitoun	Consultant ENT Surgeon	Betsi Cadwaladr UHB (YGC)

Key Themes

1 Structure and Function of the Service

Betsi Cadwaladr University Health Board provides health care to approximately 680,000 people primarily resident in the county boroughs of Anglesey, Conwy, Denbighshire, Flint, Gwynedd and Wrexham. Services are based at three main District General Hospitals (DGHs), Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd, near Rhyl, and Wrexham Maelor Hospital in Wrexham.

There is a single Multidisciplinary Team (MDT) proving Head & Neck cancer services to the population of the health board, based at Ysbyty Glan Clwyd, although some parts of the service are delivered at all three DGHs. It was noted that the current service had evolved from three separate services each with different ways of working.

Patients may be referred by their GP to ENT surgeons based at all three DGHs for investigation and diagnosis. Each ENT department operates separately from the others with their own waiting lists, separate audit meetings etc. Radiology and endoscopy facilities are available at all three sites. Recently the lead ENT cancer surgeon, who is based at Glan Clwyd, has started fortnightly clinics at Ysbyty Gwynedd to see referrals that are strongly suspected of being cancer. There is no full protocol developed yet for this clinic, and there are variations between the 4 ENT surgeons there as to at what stage in the pathway they refer to the Lead ENT cancer surgeon, however the surgeon feels that this is a good development and that ideally the clinic should be weekly as he may have to see patients in the intervening weeks at Glan Clwyd to minimise delays.

Patients with possible H&N cancers are also referred by GPs or General Dental Practitioners to the Oral & Maxillofacial Surgeons based at Ysbyty Glan Clwyd.

Following diagnosis, patients are discussed at the weekly MDT Meeting (MDM) which is based at Glan Clwyd. Colleagues from Ysbyty Gwynedd and Wrexham join sequentially by Video Conferencing to discuss only those cases diagnosed in their own centres; only the team members at Glan Clwyd are present throughout the discussion of all cases. The MDM functioned therefore as three sequential meetings rather than as a single unified MDM.

ENT Surgery is increasingly being centralised on the Glan Clwyd site with all laryngectomies and neck dissections being undertaken there by the local lead surgeon and by other ENT surgeons on an ‘in-reach’ basis but some surgery is still being undertaken at the other two sites following discussion at the MDM. The three ENT Departments function independently, managing their waiting lists separately, holding separate audit meeting etc. It was felt by some members of the MDT that the links with the ENT Department at Wrexham were less well developed than the links with ENT at Ysbyty Gwynedd.

Despite the centralisation of services, there was variation in patient management across the Health Board e.g. There were variations in practice across the three DGHs regarding voice prostheses, with different types of valves in use across the health board.

There is a 9 bedded inpatient Head & Neck Cancer Unit at Ysbyty Glan Clwyd. There had been no prior discussion of bed capacity required to support the centralisation of all ENT H&N surgery at Glan Clwyd. Centralisation has also put pressure on other services. The service had recently lost its specialist tracheostomy nurse at Glan Clwyd which was felt to have resulted in a significant gap in services. The Ysbyty Gwynedd CNS provides training / support in airways management at their base hospital.

All Maxillofacial surgery is undertaken at Glan Clwyd. Some patients are referred to centres in England for specialist surgery such as skull base surgery. The MDT feel that the need for a plastics input to the team is very limited as the maxillofacial surgeons are skilled in reconstructive surgery including free flaps, however patients can be referred to the Plastic Surgery Centre at Whiston Hospital on Merseyside if appropriate. However the MDT stated that the Plastic Surgery Centre at Whiston does not have significant Head & Neck cancer specialist expertise. The maxillofacial service has developed close links with colleagues n the Merseyside Regional Head and Neck Cancer Centre and share outcome and other audit data with them.

The surgeons reported that it was usually possible to access additional operating lists, but the capacity to undertake such lists was limited by lack of time in their job plans, and it was difficult to get three-session lists which were necessary for the more complex cases.

There have been occasions when maxillofacial surgical cases have been cancelled due to the lack of Intensive Care (ITU) beds. Approximately 2-3 cases annually (c.10% of all free-flaps) are cancelled. If a patient is cancelled, they may have to wait up to a week to be re-listed. It was suggested that the inclusion of an anaesthetist as a formal member of the MDT could help with the management of these patients. It was noted that whilst waiting time breaches were reported to the Board, cancelled cancer operations weren't routinely reported.

Currently laser surgery capacity is available at both Ysbyty Glan Clwyd and Wrexham. The MDT had undertaken an audit of the service and recognised that laser surgery should be centralised. The number of patient having laser surgery is quite low, so the MDT are currently sending all cases to Wrexham where the ENT surgeon with the most experience in laser surgery is based. This may need to be reviewed as a centralised ENT Head & Neck surgery service is developed at Glan Clwyd to ensure that laser surgery patients have access to the same support services as other surgical patients. The MDT acknowledged the need to develop their laser surgery service.

Clinical oncology is based at the North Wales Cancer Treatment Centre (NWCTC) at Ysbyty Glan Clwyd; the oncologists run out-reach clinics at the other DGHs weekly and provide support to the locally based MDT members. The MDT stated that they have sufficient clinical oncology input at all the hospitals. Radiotherapy is provided at the North Wales Cancer Treatment Centre; there are Chemotherapy Units at all three DGHs.

The Peer Review Team congratulated the MDT on its very high rate of Intensity Modulated Radiotherapy Treatment (IMRT) (97%), however they also noted that the 2013 National Audit of Head & Neck Cancer Services (DAHNO) showed that the North Wales Cancer Network had the longest radiotherapy waiting times in the UK with the median interval between diagnosis and start of radiotherapy being 61.5 days and 57.0 days for chemo-radiotherapy and 66 days from date of surgery to the start of post-operative radiotherapy. In the self-assessment documentation provided to the Peer Review team, the MDT reported that 0% of patients had met the maximum target of 42 days from

surgery to post-operative radiotherapy (range 49-103 days) and only 59% of patients (17/29) had started definitive radiotherapy treatment within 28 days of the decision to treat date (the target is 95%).

The MDT explained that there were particular bottlenecks caused by a shortage of staff in Medical Physics and therapeutic radiography and also lack of linear accelerators (linacs). The NWCTC has 4 linacs but only three are funded for operation. The recent report national report "Radiotherapy Equipment Needs and Workforce Implications 2006-2016 (Update Report To 2020)" showed that the centre had the highest level of productivity per linac in Wales. There was no additional funding provided for the implementation of IMRT. Lack of capacity in the Chemotherapy Day Unit at Glan Clwyd also contributed to delays in chemoradiotherapy.

There is a therapeutic radiographer present at the MDT Meetings who liaises with the oncologists to book patients into slots for radiotherapy planning and treatment as soon as possible to reduce delays.

There was a wish to appoint a specialist radiographer to support the Head & Neck cancer team, but no business case had been developed.

Pathology was also a factor in delays for post-operative radiotherapy, with the oncologists suggesting that there could be a delay of 3-4 weeks for post-operative pathology reports being available. A lack of staff in the pathology department was acknowledged. The pathology service had recently centralised onto the Ysbyty Glan Clwyd site, and was felt to be still evolving. HPV testing is not routinely undertaken as part of pathology reporting protocols, however it is becoming more commonplace in line with current UK Royal College of Pathology reporting guidelines. The MDT questioned whether it actually changed the treatment plan.

Diagnostic and staging radiological examinations are carried out on all three DGH sites. There are six radiologists who are members of the MDT, two on each DGH site however there is no cross site reporting to provide cover or to better manager workload. Currently the MDT was experiencing 2-3 week delays for Ultrasound, CT and MRI at Ysbyty Glan Clwyd and Wrexham Maelor which they stated were because of staff and equipment shortages. There was no formal target for imaging cancer patients, but the department tried to do investigations for USC patients within 2 weeks. There were no 'ring-fenced' slots for staging scans. The MDT co-ordinator and the CNSs track patients and liaise with radiology to try and expedite patients. It was noted that once an investigation is carried out, reporting is carried out very quickly.

2 Patient Centred Care and Experience

There are Head & Neck Cancer Nurse Specialists based at the three DGHs. The CNS at Ysbyty Gwynedd is also a nurse specialist for ENT so spends approximately 0.6wte dedicated to H&N cancer. The H&N Cancer nurse specialist at Wrexham Maelor Hospital is part-time. There is 1.0wte CNS at Ysbyty Glan Clwyd, but this post covers both surgery and oncology. Wherever possible the CNS are in clinic to provide support to patients at diagnosis, however the lack of resources means that not all Head & Neck clinics across the health board can have CNS support, and the lack of cover for all the posts for annual leave etc can make this position worse. The CNS at Ysbyty Gwynedd is planning to retire

shortly and return on a part-time basis; there are no agreed plans to recruit to cover the shortfall.

The Review Team noted that the CNS at Ysbyty Gwynedd undertakes home visits which he feels gives a wider view of the social situation of the patient, and helps inform the support that the patient will require. The home visits from Ysbyty Gwynedd will cease when the current CNS becomes part-time. The CNS at Glan Clwyd has already had to stop undertaking home visits because of workload pressures.

The MDT accepted that their focus had been on clinical management and the centralisation agenda, and that there was less of a focus on the proactive provision of holistic care for patients, though they stressed that they were able to respond to individual patient needs, such as the ability to access psychological support.

Holistic Needs Assessment was being rolled out across the Health Board, and the Board had recently appointed a Patient Centre Care Manager, funded by Macmillan, post to lead on this

a. Evidence of Key worker

The appointment of a Key Worker is not made by the MDT; it is usually a role taken up by whichever CNS sees the patients first. The MDT recognised the need to formalise and record the appointment of the Key Worker.

3 Service Quality and Delivery

a. MDT Service Support

The Review Team recognised the strong input to the MDT provided by the Consultant in Restorative Dentistry. Although based at Wrexham Maelor, he holds weekly clinics at Ysbyty Glan Clwyd and fortnightly Clinics at Ysbyty Gwynedd where he tries to ensure that he sees all appropriate patients for a pre-treatment assessment, particularly radiotherapy and chemo-radiotherapy patients. However the fact that he is single handed does limit his ability to undertake post-treatment assessment although he is able to undertake some dental implant work. The fact that he can only visit Ysbyty Gwynedd every two weeks, may lead to delays in treatment for patients from the west of the HB area. It was noted that patient expectations for their dentition following treatment had increased, leading to a greater demand on the service. The Consultant is planning to retire in the near future, and felt that there had been little succession planning. A Job Description had been developed, but there were particular problems in getting Royal College approval for a single-handed post for the past six months.

The Peer Review team queried how well Dietetics and Speech and Language Therapists (SALTs) were integrated into the MDT.

A dietitian was present at only 37% of the MDT meetings. There was only one dietitian to support the MDT and the service that could be provided was limited. Artificial feeding such as PEG (Percutaneous Endoscopic Gastrostomy) and RIG (Radiolgically Inserted Gastrostomy) is discussed at the MDT meeting, but the decision for feeding is usually made by the oncologist. The dietitian is not involved in the decision but provides support. Radiotherapy patients were seen weekly in a joint clinic with the CNS at Glan Clwyd,

however there was no SALT present. There were nutrition support nurses in the community, but patients could only be fully assessed when they came to the cancer centre.

There were two SALTs at Ysbyty Glan Clwyd but they were not dedicated to Head & Neck cancer; they try to see all patients when they attend for radiotherapy. Follow-up is transferred back to Ysbyty Gwynedd and Wrexham Maelor for patients from those areas; neither hospital has a head and neck specialist SALT attached to the Head & Neck clinics. However, there is a weekly meeting at Ysbyty Gwynedd for the CNS, dietetics and SALT to discuss cases from that area. In the west of the health board, there are particular problems in patients accessing community services in rural areas, and there can be significant delays. The MDT felt that the lack of dietetics and SALT services meant that there was not an equitable service for all patients; most got a very good service but a number didn't, and this could affect their quality of life. It was stated that Dietetics assessments were more likely to be reactive than proactive.

b. <u>Service Outcome Data</u>

	BCU	Target
Number of USC referrals treated within 62 days	71%	**Target 95%**
Average (median) days until diagnosis.	26	
% of patient with pre-treatment stage recorded.	90%	**Target 85%**
Average (median) days to first treatment.	47	
% completion of co-morbidity	0%	**Target 75%**
% number of New patients seen by specialist nurse.	61%	**Target 100%**
Percentage of patients with 30 day post treatment mortality for: a) Chemotherapy b) Surgery c) Radiotherapy		
a) Chemotherapy	3%	
b) Surgery	0	
c) Radiotherapy	7%	
Number of patients entered into clinical trials	2010/11 = 3; 2011/12 =2	
Number of patients donating tissue to the Wales Cancer Bank.	0	
% of patients starting definitive RT within 28 days of Decision to Treat Date	**59%**	**Target 95%**
% of radical patients being treated with IMRT	97%	**Target 80%**

% of patients starting post op RT within 42 Days of surgery	See Q49	Target 95%
Overall rating of care excellent/ very good Head & Neck	95%	
Survival Data		
1 Year 5 Year 5 Year Consolidated	79.77 59.98 68.1	

c. Key audits, projects and outcomes

The Lead consultant carries out regular audits on the current service provided.eg T4 patients, USC referrals etc, and regularly attends the ABMU Audit meetings where audit outcomes are discussed, and fed back to the Directorate managers. The team were not aware of their survival data.

Recruitment to Clinical Trials was very low (2 patients in 2011/12). Although there is a thriving trials unit at Glan Clwyd, support to the Head & Neck service is poor, and there is also only 0.7wte research therapeutic radiographer to cover all cancer sites. Recently recruitment had improved with 15 patients entered into the ART DECO trial and there were plans to participate in the De-ESCALaTE HPV trial.

There was a strong history of research into swallowing disorders, and the MDT were proud that the Cancer Centre had had the first Swallowing Workstation in the UK, and had been able to get funding for a research post looking at swallowing problems following treatment for head & neck cancer, in collaboration with Bangor University.

d. General Observations

The Peer Review Team suggested that the Self-Assessment return prepared by the MDT was lacking in some areas e.g. the overall assessment against each of the three themes had not been completed, and the MDT had not therefore identified their priorities for improvement and what actions they planned. The MDT agreed that there could have been better engagement with management in completing the returns. The MDT Lead acknowledged that after undertaking Peer Review in other Health Boards, there was a greater awareness of the detail required in submissions.

4 Engagement with Management

There is a weekly meeting of the Cancer & Palliative Care Clinical Programme Group (CPG) but it appeared that this was focussed on Health Board issues such as the budget. The fact that Radiotherapy Physics was in a different CPG meant that there was no single line of accountability for the radiotherapy service. The Peer Review Team noted that the NWCTC did not routinely collect its radiotherapy waiting times data, and suggested that this should be rectified and such data regularly brought to the attention of the CPG and the Board.

Members of the MDT suggested that although the Health Board stated that cancer was a Level 1 Priority, this wasn't necessarily demonstrated in actions. The major issues for the

Health Board related to Unscheduled Care, and trying to manage a cancer service in this context was very difficult.

The Health Board did not have a formal lead cancer clinician at the time of the peer review visit, and the MDT were not aware of a forum where they could escalate issues especially if they concerned more than one CPG, other than to go to the Medical Director as he had previously been the Chief of Staff for the Cancer & Palliative Care CPG. There was no forum for MDT leads across different sites to meet and raise issues with senior management. It was noted that a new Chief Executive had recently been appointed, and current management arrangements and structures were being reviewed.

The lead managers for surgery for each of the three DGHs meet weekly with the Cancer Performance Manager to review patient tracking information against the 31 and 62 day treatment targets. In addition a number of indicators are discussed monthly with the Chief Operating Officer but these do not include routine data on waits for radiotherapy or chemoradiotherapy. The MDT was not aware of the current waiting times for radiotherapy.

5 Culture of the Teams

The Review Team welcomed the opportunity to see the MDT meeting in action. It was clearly a cohesive team, made up of committed clinicians, The review team particularly noted the proactive support provided to the MDT by the MDT co-ordinator, the therapeutic radiographer and the consultant in restorative dentistry.

However, one member reported that they felt like an 'add-on' to the MDT, and the Review Team noted that in its Operational Policy, SALTs and dietitians were listed as 'Support Service Members' rather than as 'Core MDT Members'

There are ad-hoc Business Meetings of the MDT, but issues such as the DAHNO audit results have not been discussed by the team. The MDT agreed there was a need to have more regular business meetings.

Good Practice/Significant Achievements

- Survival data for Head & Neck Cancer is the highest in Wales
- The proactive support provided to the MDT by the MDT co-ordinator, the therapeutic radiographer and the consultant in restorative dentistry
- The strong focus on research into swallowing disorders, including the first Swallowing Workstation in the UK, and the research post looking at swallowing problems following treatment for head and neck cancer.

Immediate Risks

- None

Serious Concerns

- Waiting times for radiotherapy were the worst in the UK (DAHNO 2013). There is also no mechanism for routinely reporting on these and other pathway delays to senior management.

Concerns

- There were variations in pathways between the three DGHs including in the provision of aftercare, voice prostheses etc leading to inequitable access to some services. The Health Board may wish to consider developing common protocols for use across the region.
- Lack of resources in CNS, SALT, and Dietetics services means that whilst they are very patient centred and patient-focussed, support for patients is precarious and primarily reactive rather than proactive, and also not consistent across the health board region.
- There are delays of 3-4 weeks in pathology reporting time which can impact on starting post-operative radiotherapy or chemoradiotherapy treatment. There are also delays in accessing radiological investigations, although subsequent reporting is very good.
- There is no evidence of a strategic plan for head and neck cancer, e.g. bed capacity in the light of centralisation, and pressure on ITU services. Also there appears to be a lack of planning for the impending retirement of key individuals and therefore concerns over the resultant future of services.
- There was a ‘disconnect’ between the clinical teams and management which appeared to affect the ability of the service to develop and change. There is no Health Board Cancer Lead Clinician to act as a focal point for MDTs and a bridge between clinical teams and the senior management structure.
- The Multi-disciplinary Team Meeting is a series of sequential DGH based meetings rather than a unified Health board wide meeting. A unified meeting, recognising the core role of all members, could help to support cross cover, promote common protocols and pathways etc

- Lack of support for clinical trials activity in Head & Neck cancer e.g. H&N trials nurse, and research radiographer.