University Hospitals Bristol NHS
NHS Foundation Trust

Annual Report

Lung MDT

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Agreement and Approval

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Date 27/09/2012 Signature (agreed via email)

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Date 26/09/2012 Signature (agreed via email)

Review Date

Next report due August 2013

Versions

Version	Date	Reason	Sign Off
1.0	11/05/10	Draft revision for 2010 Peer Review	
2.0	15/08/11	Revision for 2011 Peer Review	
3.0	Sept 12	Revision for 2012 Peer Review	27/09/2012

1 Measure Checklist

Measure Number	Measure	Operational Policy	Annual Report	Work Plan	Supporting Information
11-2C-101	Lead Clinician and Core Team Membership	p6, p7			
11-2C-102	Level 2 Practitioners for Psychological Support	p13	p11		
11-2C-103	Support for Level 2 Practitioners	p13	p11		p4
11-2C-104	Team attendance at NSSG meetings	p10	p6		
11-2C-105	MDT Meeting	p9			
11-2C-106	MDT agreed cover arrangements for core members	p6			
11-2C-107	Core member (or cover) present for 2/3 of meetings		p6-7		
11-2C-108	Annual meeting to discuss operational policy	p10	p10		p5-13
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11-2C-110	Policy for communication of diagnosis to GP	p11	p14	p9	p14
11-2C-111	Operational policy for named key worker	p12	p14	p9	
11-2C-112	Core histopathology member taking part in histopathology EQA	p15	p14		p15-16
11-2C-113	Core nurse member completed specialist study	p8	p11		
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11-2C-125	MDT/network agreed collection of minimum dataset	p15	p12	p5	
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11-2C-127	MDT/NSSG agreed list of approved trials	p15	p18	p8	
11-2C-128	Joint treatment planning for TYA patients	p10	p9		

2 Contents

3 Introduction

This Report relates to the operational period April 2011 – March 2012. This period has seen a number of issues, challenges and successes as outlined below. This report will be discussed and agreed at the next Lung Operational Meeting.

3.1 Key Achievements

- Full integration of second lung cancer specialist nurse into service. All oncology clinics now covered allowing continuity for patients between initial attendance for diagnosis, discussion of treatment, and support thereafter
- High lung cancer resection rates above the national average including 70% of lobectomies performed by VATS which is less invasive and allows faster patient recovery
- Integration of fourth thoracic surgeon into team
- High rates of treatment with chemotherapy for small cell and non-small cell lung cancer
- Steady improvement in submission to LUCADA
- Maintaining an efficient diagnostic service leading to clinic review, staging, histological confirmation, and MDT meeting review often within a week and almost always within 2 weeks
- Involvement in setting up and recruiting to the locally initiated SMART trial of port site radiotherapy for mesothelioma
- On-going recruitment of patients to a portfolio of national clinical trials

3.2 Key Challenges

- Maintaining efficient passage of patients through the diagnostic and treatment pathway in the face of bed and financial pressures in the trust
- Maintaining a high quality regional thoracic surgical service with limited theatre availability
- Appointment of a new respiratory physician with an interest in thoracic malignancy
- Cover for the usual clinical oncologist due to extended leave
- Updating all treatment protocols in a timely manner
- Starting a new nurse-led clinic to explain the diagnosis to the patients after MDT confirmation
- Maintaining CNS support to all patients with thoracic malignancy given constraints on allocated nursing time (currently 1 WTE, MDT working to secure more)
- Pressures on oncology clinics due to more complex, and further lines of, cancer treatment
- Further improvement in the quality and standards in data submission to LUCADA. To be achieved by a combination of a continued focus on data collection at the MDT meeting, an on-going focus on maintaining high standards surrounding diagnosis and treatment, and data checking before submission by MDT Lead, MDT Coordinator and the Cancer Services Manager

4 Meetings

4.1 Team Attendance at NSSG Meetings (11-2C-104)

The Lung NSSG held the following meetings during April 2011-March 2012, with the MDT represented as follows.

Meeting Date	Name	Job Title
17th June 2011	Adam Dangoor Lois Philips Gianluca Casali	Oncologist and MDT lead CNS Surgeon
2nd December 2011	Tim Batchelor Martin Hetzel	Surgeon Physician
Overall % Attendance	**100**	

For further details of the meetings please see the Network Annual Report

4.2 MDT Meeting Attendance (11-2C-107)

MDT attendance is captured using a live data base – the Somerset Cancer Register. Using this to record MDT attendance provides a more accurate attendance record. A full breakdown of the MDT meeting attendance for the year for core roles/members is shown below.

4.2.1 By Role

Role	**Attendance**
Lead Clinician	76%
Respiratory physician(s)	96%
Thoracic surgeons (s)	96%
Clinical Oncologist (s)	90%
Radiologist (s)	94%
Histopathology (s)	98%
CNS	92%
Palliative Care	58%
MDT Co-ordinator	100%

4.2.2 Individual

Role	**Name**	**Attendance**
Lead Clinician for MDT	Martin Hetzel*	76%
Respiratory physicians	Liz Gamble James Catterall Adam Whittle Nabil Jarad	64% 68% 46% 62%

Thoracic surgeons	Tim Batchelor Frank Collins Gianlucca Casali Doug West**	42% 40% 46% 53%
Histopathologist/ cytologist	Golda Shelley-Fraser Nidhi Bhatt	36.73% 42%
Radiologists	Paula Murphy	62%
Clinical Oncologist	Adam Dangoor Paula Wilson	66% 62%
MDT Co-ordinators	Carrie Trott	84%
Clinical Nurse Specialist	Lois Phillips Michelle Samson	64% 64%
Palliative Care	Colette Reid	58%

***** Lead Clinician during 2011-12, retired April 2012 and replaced as lead by Dr Dangoor
****** Joined MDT July 2011

Note: Cover for each meeting for MDT members is arranged between individuals in each specialty as required and the MDT co-ordinator informed.

4.3 Workload of MDT / Cases discussed

- Meetings were held weekly on a Friday within the MDT meeting room in the Radiology department. 2 meetings were cancelled due to multiple absences or bank holidays. This did not have a detrimental effect upon patient pathways as cancellations were carefully planned and patient cases were discussed the week immediately prior or immediately following the cancelled meetings.
- The MDT successfully manages the organisation, preparation and administration of meetings with the MDT Coordinator using a live database – the Somerset Cancer Register - to record and capture outcomes of MDT discussions.

There were 747 patients referred to UH Bristol with known or suspected lung cancer

Priority	**Total**
Two Week Wait Fast Track	236
Consultant Upgrade (will include tertiary)	321
Other (includes GP non-fast-track)	190
Total	**747**

There were 481 patients diagnosed with cancer at UH Bristol in the review period:

Primary	374
Metastasis	97
Recurrence	10
Total	**481**

- Cases split by final diagnosis

Diagnosis	Total
C340 - Malignant neoplasm of main bronchus	16
C341 - Malignant neoplasm of upper lobe, bronchus or lung	120
C342 - Malignant neoplasm of middle lobe, bronchus or lung	16
C343 - Malignant neoplasm of lower lobe, bronchus or lung	62
C348 - Malignant neoplasm of overlap les of bronchus & lung	7
C349 - Malignant neoplasm of bronchus or lung, unspec	155
C37X - Malignant neoplasm of thymus	3
C381 - Malignant neoplasm of anterior mediastinum	4
C382 - Malignant neoplasm of posterior mediastinum	1
C384 - Malignant neoplasm of pleura	8
C399 - Malignant neoplasm of ill-def sites within the resp sys	1
C450 - Mesothelioma of pleura	30
C459 - Mesothelioma, unspecified	2
C760 - Malignant neoplasm of head, face & neck	1
C761 - Malignant neoplasm of thorax	1
C764 - Malignant neoplasm of upper limb	1
C771 - Sec & uns malignant neoplasm of intrathoracic lymph nodes	2
C780 - Secondary malignant neoplasm of lung	15
C781 - Secondary malignant neoplasm of mediastinum	3
C782 - Secondary malignant neoplasm of pleura	1
C783 - Secondary malignant neoplasm of oth & unsp respiratory orgs	1
C788 - Secondary malignant neoplasm of other & unsp digestive orgs	1
C790 - Secondary malignant neoplasm of kidney & renal	2

pelvis	
C792 - Secondary malignant neoplasm of skin	2
C793 - Secondary malignant neoplasm of brain & cerebral meninges	1
C795 - Secondary malignant neoplasm of bone and bone marrow	2
C798 - Secondary malignant neoplasm of other specified sites	17
C80X - Malignant neoplasm without specification of site	4
C857 - Other specified types of non-Hodgkin lymphoma	1
D36 - Benign neoplasm of other and unspecified sites	1
Total	**481**

- Treatments (first definitive only, some patients may have had more than on treatment)

Treatment Types	**Total**
Active Monitoring	27
Anti Cancer Drug (Cytotoxic Chemotherapy)	56
Chemoradiotherapy	1
Non-Specialist Palliative Care	1
Specialist Palliative Care	28
Surgery	233
Teletherapy (Beam Radiation excl. Proton Therapy)	100
Not recorded*	35
Total	**481**

*This may be due to treatment not having started at the time of the data snapshot, or a patient undergoing first definitive treatment at another provider e.g. following diagnostic surgery at UH Bristol

4.4 TYA patients (11-2C-128)

There were no Teenage or Young Adult (TYA) patients (aged 15-24) diagnosed by the MDT in the review period and therefore no referrals were made to the TYA MDaT.

4.5 Annual Meetings (11-2C-108)

The MDT held its Annual General Meeting on 8th November 2011 to review both operational and strategic developments. Minutes of the meeting are available in the supporting information on pages 5-13. The 2012 AGM is planned for November.

4.6 Lung Cancer MDT Core Group meetings (11-2C-108)

Besides the weekly MDT meetings the Lung team has formed a Lung Cancer MDT Core Group. The aim of the group is to raise the standards of the lung MDT (performance, innovation, research etc). A representative from each discipline meets every 2-3 months. This meeting is in addition to the MDT AGM.

Members of the Lung Cancer Core group are:-

- Respiratory medicine – Martin Hetzel replaced by Liz Gamble
- Thoracic surgery - Tim Batchelor
- Oncology - Adam Dangoor (lead clinician)
- Radiology – Rebecca Duerden / John Hughes
- Histopathology – Golda Shelley-Fraser/Nidhi Bhatt
- CNSs - Lois Philips/ Michelle Samson/Sophie Fox
- Palliative Care – Colette Reid
- MDT Coordinator - Carrie Trott

5 Training

5.1 Advanced Communications Skills Training Course (11-2C-115)

The following clinical members of the core team with direct patient contact have completed the NCAT 'Advanced Communications Skills' training course:

Adam Dangoor, April 2003 (3-day CRUK Communication Skills in Cancer Care course)
Paula Wilson, 5-7th April 2011
Michelle Samson, 27-29th September 2011
Sophie Fox, October 2011
Lois Philips 14-16 December 2010
Colette Reid 9-11th April 2008
Golda Shelley-Fraser 28-29 February 2012

The rest of the clinical core members with direct patient contact intend to undertake the training at the earliest opportunity, depending on the availability of courses.

5.2 'Breaking Bad News' Communications Skills Training Course

All MDT members except Mr Casali (who was more recently appointed appointed) attended an Internal Training Programme on the 'Breaking of Bad News' on 13 October 2009. Michelle Samson teaches on the course.

5.3 CNS Training (11-2C-113)

- Michelle Samson has completed the BSc (hons) Professional Studies -Cancer Care pathway, and MSc Advanced Practice and Lois Phillips has completed BSc Palliative Care
- Michelle Samson has completed a one day communication module as part of the MSc Advanced Practice, Lois Phillips has completed the same module at level 3 as part of BSc Palliative Care

5.4 Level 2 Psychological Support – Training and Supervision (11-2C-102, 11-2C-103)

Lois Philips and Michelle Samson have undertaken the Trust's Network approved training to provide level 2 psychological support to patients and carers. The Trust has recently secured funding to establish monthly clinical supervision for CNSs with respect to this role, by a level 4 clinical psychologist.

5.5 Training Forum for Medical Staff

The MDT provide a forum for training juniors and informing medical students of the process and function of a MDT- this meeting provides multi-professional training, e.g. the nurse specialists often bring nursing students or new staff nurses to the MDT to show the benefits of multi-disciplinary working and learning. Junior doctors training in Radiology, Respiratory Medicine, Thoracic surgery, and oncology regularly attend for training and are encouraged to present/ comment on individual cases. Junior doctors and registrars present some patient cases at the weekly MDT. Also Respiratory registrars participate in Lung Cancer Clinics under Clinician Supervision.

6 Data Collection

6.1 Data Collection (11-2C-125)

Data capture and submission has continued to improve, although a number challenges remain. The UH Bristol MDT has agreed the Network's minimum dataset and aims to collect this. Data is captured electronically using the Somerset Cancer Register (SCR). The team is committed to collecting good data and considerable time and effort is being spent in doing so. The problems with data quality for lung are now mainly around technicalities regarding the upload of data for subsequent analysis.

The Somerset Cancer Register was upgraded in 2012, and the new version provides clearer indicators of where to enter data, and better reporting tools for monitoring data quality. A demonstration on good practice in data entry by the Somerset Cancer Register team is planned for the Lung SSG in 2012.

Better monitoring to highlight gaps in clinical data is being put in place with the new register and the clinical team will check data submissions to LUCADA (the national lung cancer audit).

As at mid-June 2012, the LUCADA submission for 2011 data showed 96% had performance status recorded, 89% had staging recorded, and 87% both staging and PS. Further data improvement work may further increase these figures, which are already well above the national average.

In addition, an audit of data collection for patients first treated in quarter 4 of 2011/12 showed 93% had treatment intent entered, 94% surgical cases had a SNOMED code entered, 98% a pathology report, and 92% a procedure code. 100% records had at least one MDT discussion recorded.

6.2 NLCA – LUCADA Data

The LUCADA 2011 data report (based on patients first seen in 2010) was disappointing for UH Bristol, with a low number records having both performance status and staging recorded. This has been identified as being due to problems with the upload of information into the national database, which have been rectified for the 2012 submission.

Due to the absence of these indicators, other data was disregarded, for example chemotherapy records. Therefore the results do not give an accurate picture of the service offered or indeed of the data capture arrangements. The 2011 submission has hugely improved the completeness of these key fields (see above). With these data being captured routinely in the right place going forwards, next year's data quality work can focus on other areas of the dataset.

7 Clinical Lines of Enquiry

Clinical Lines of Enquiry are based on the LUCADA dataset of 2010. As explained above, there were issues with the data upload to this audit which mean it does not represent accurately all aspects of the service. Therefore where available more accurate, up-to-date figures from the Somerset Cancer Register have been provided.

Metric 1: The percentage of expected cases on whom data is collected

Around 80% is expected, as this number will naturally vary from year to year. UH Bristol achieved 94%.

Metric 2: The % histological confirmation rate

UH Bristol achieved 83%, above the national average of 76%.

Metric 3: The percentage having active treatment

UH Bristol achieved 69%, above the national average of 54%

Metric 4: The percentage undergoing surgical resection (all cases excluding Mesothelioma & confirmed Small Cell Lung Cancer)

20.6% of all non-small-cell lung cancer patients first seen at UH Bristol received surgery. This compares to a national average of 13.7%. This result is likely to reflect the availability of thoracic surgery at UH Bristol and its role as a regional centre for such surgery.

Metric 5: The percentage of small cell cancer patients receiving chemotherapy

83% of small-cell lung cancer patients first seen at UH Bristol received chemotherapy, compared to a national average of 65%.

It should be noted that for all metrics except metric 4 there is a significant difference in the composition of the Trust's population from the LUCADA population overall.

8 Audits

8.1 NSSG audits (11-2C-126)

The Trust participated in the NSSG audit, 'CNS capacity – breaking bad news and CNS referrals'. Results of the audit were presented at the June 2011 meeting of the NSSG. The audit recommended triaging of cases for clinics in order to make most efficient use of CNS time. It noted that CNSs were not always available to visit inpatients and may therefore not be present at the time of diagnosis.

The Trust is participating in the new NSSG audit, 'Routes to Diagnosis 2012'. This is a prospective audit of all patients, looking at route of referral, symptoms before referral, and stage/performance status at diagnosis. The audit runs from 1st March to 30th August 2012 and results will be presented in the next annual report.

8.2 EQA Audit (11-2C-112)

The pathology services within UH Bristol have full CPA accreditation across its labs.

The Lung Core MDT Pathologists Golda Shelly-Fraser and Nidhi Bhatt participate in the Pulmonary EQA scheme. Evidence of participation in the review period has been received and is included in the supporting information on pages 15-16.

8.3 Audit of Timeliness of Diagnostic Notification to GPs (11-2C-110)

Review of this measure revealed the previous process for notifying GPs within 24 hours was not working in practice. Therefore it was not considered worthwhile to carry out an audit this year. This will be addressed by a new nurse-led clinic where patients are told the results of diagnostic tests and informed where they will be seen next to arrange treatment.

8.4 Key Worker (11-2C-111)

The MDT has a policy for ensuring a keyworker is allocated, but has recently changed the policy for ensuring this is recorded clearly in the notes. There is a plan to audit this in the next six months to ensure the policy is working.

9 Patient and Carer Feedback and Involvement (11-2C-118)

9.1 Patient Focus Group

The Lung Cancer Clinical Nurse Specialist in conjunction with the Upper Gastrointestinal Clinical Nurse Specialists organised a focus group for patients who had used services over the past eighteen months.

The event took place on the 28th February 2012 for 90 minutes. 50 participants were invited from each speciality, and 12 participants agreed to attend.

2 patients having had treatment for lung cancer
6 patients having had treatment for oesophago-gastric cancer
3 patients having had treatment for pancreas cancer

There were two focus groups with Jo Witherstone (Upper GI Clinical Nurse Specialist) and Michelle Samson (Lung Cancer Clinical Nurse Specialist) as facilitators. Each group was asked to talk about their experiences of the service, what went well and what could be improved.

All the participants enjoyed the experience and would be keen to join in something similar again. Notes were taken during the discussions to capture all the conversations. These were sent to each participant after the event.

Themes Elicited from the Conversations

Cancer diagnosis / Treatment discussion

- "Blunt is good needs to be backed up with a bit of velvet"
- "Objectively firm but friendly"
- "Have to put trust into person who tells you what's ahead"
- "Partnership between yourself and the medical team"

Care in Hospital

- Sometimes felt that the care provided was pulling in different directions in terms of the treatment / care plan
- Most nurses were wonderful, some impersonal. Some were quite blunt and didn't seem to care
- Consultants' attitude was "deal with the experts, forget the amateurs" – they cut the GP out.
- Intensive care ward – patients need more information about what to expect
- At out-patient appointments – May need an x-ray before consultation, never happens – perhaps a checklist with outpatient letter may help.

Carers / Family

- "Share the pain, share the journey"
- Every patient should have an advocate to hear and understand difficult information.
- Patient cannot hear everything, or advocate for themselves – too emotionally involved
- Support for carers is very important – "keep all the plates spinning to keep the family unit together"

Patient Information

- Information about treatment and what to expect earlier in the pathway to enable patient and family to prepare and ask questions
- Pre-operative information about medications, especially those that may cause hallucinations – very frightening
- Increase in the psychological support for patients around what to expect with treatment

- More information about the Intensive care ward and what to expect
- There is good written information – ensure everyone has access
- More information about what to expect at home and who is available for support

Support

- "Patient feelings are more important than thoughts"
- Feeling of a gap between the hospital and home
- Where to seek support – Clinical Nurse Specialists need to be clear about what service they can provide and when they are available to discuss concerns
- Post-traumatic stress and personality changes – need information

Summary

Ares for further discussion / Service improvement

- All the participants thoroughly enjoyed coming together to discuss their experiences and were keen to be involved in something similar
- "Keen to give something back"
- Many participants were willing to come and meet other patients – Buddy system
- Clinical Nurse Specialists to think about ways to ensure that they are available through the week for patient queries and concerns
- Support for Carers – Carer assessments
- Review information – Upper GI website now available www.uhbristol.nhs.uk/uppergi.

This work will be written-up to be published in a nursing journal.

9.2 National Cancer Patient Experience Survey

The results of the 2011/12 national cancer patient experience survey were received shortly before the self-assessment. Fuller results, including countrywide comparisons and patient comments, are expected in the near future and will enable a better analysis and actions to be drawn up.

83 patients with lung cancer responded to the survey. It is not known yet what treatment types these patients had, or whether their entire pathway was at UH Bristol.

Most results were within 10% of the national average. The best questions compared to the national average were 'patient never thought they were given conflicting information' (84%), 'patient had confidence and trust in all doctors treating them' (90%), staff gave a complete explanation of what would be done (during operation)' (91%), and 'patients completely understood the explanation of what was wrong' (81%). 89% patients rated their overall care as 'very good' or 'excellent'.

Eight results were more than 10% lower than the national average, and these are areas we will be targeting to improve. The questions in this group were:

- Patients were told they could get free prescriptions (although significantly improved from 2010)
- Hospital staff gave information on getting financial help (again improved from 2010)
- Patient's views definitely taken into account by nurses and doctors discussing treatment
- Patient given written information about side effects
- Patient finds it easy to contact their CNS
- Family definitely given all the information they needed to help care at home

- Hospital and community staff always worked well together

- Hospital staff definitely gave patients enough emotional support

Actions completed as a result of the last patient experience survey included improving the information available to patients about benefits advice and financial help, appointment of a cancer patient user representative to Cancer Board, installation of Macmillan ‘info points’ staffed by volunteers around the Trust, establishment of a new acute oncology service for patients with emergency presentations or complications of oncology treatment, establishment of a CNS and AHP forum, and physical improvements to the BHOC environment and outpatient area.

9.3 User involvement

The MDT has identified two patient representatives who have attended team meetings to provide a patient’s perspective, and took part in the publicity surrounding the lung cancer awareness campaign in the local media.

10 Research and Trials

10.1 Clinical Trials (11-2C-127)

The MDT lead Dr Adam Dangoor is the network lung cancer research lead and recently joined the NCRI Lung Cancer Clinical Study Group. Patients are recruited to a number of national and local clinical trials; both NCRN badged and commercial. These include:

Non-small cell lung cancer: ET trial, CHART-ED, QUARTZ, FORTIS-M, LUME-Lung

Small cell lung cancer: CONVERT

Mesothelioma: SWAMP

The table below shows the MDT's recruitment to trials, from the Research Network NSSG report. The NSSG's endorsed trials are ET-Trial and SMART.

	Status UH B	Recruitment 11/12
CHART-ED	Open	1
CONVERT	Open	4
ET-Trial	Open	4
MALCS	Open	2
QUARTZ	Open	4
REST	Open	3
SMART	Open	0
FORTIS-M	Closed	0
LUME	Closed	0
OSI-906	Open	0 (patient in screening at the moment)