National Cancer Peer Review

PEER REVIEW VISIT REPORT

(MULTI-DISCIPLINARY TEAM)

Network	GMCCN	
Organisation (Trust)	SALFORD ROYAL	
Team	Salford Specialist Upper GI MDT (11-2F-2) - 2011/12	
Peer Review Visit Date	13th September 2011	
Compliance		
SPECIALIST UPPER GI MDT	**Self Assessment** 84.9% (28/33)	**Peer Review** 87.9% (29/33)
Zonal Statement		
Completed By	Millie Forde	
Job Title	Assistant Quality Manager	
Date Completed	25.11.11	
Agreed By (Clinical Lead/Quality Director)	Catriona Calvert	
Date Agreed	25.11.11	
Key Themes		
Structure and function of the service		

There is evidence of strong and inclusive leadership of this MDT with all core members in place. The team are to be commended for the management of the smooth recent reconfiguration of the service to include clinicians from Pennine Acute Hospitals NHS Trust, Wrightington, Wigan & Leigh NHS Foundation Trust and Royal Bolton NHS Foundation Trust as core MDT members.

All core specialities meet the required attendance at the weekly MDT meetings. Some specialities that have several core team members from the same Trust, attend the MDT meetings on an informal rota basis so personal attendance levels are slightly below what would be expected.

There is a good network of CNSs from the across all localities, with excellent communication between those nurses based at the specialist centre and those within the local teams. Not all CNSs listed as core members of the team have undertaken specialist study, but there are plans in place to ensure that all team members will have formal, recognised appropriate qualifications.

The Trust meet the relevant waiting standards for the urgent 2 week wait GP target and the 31 day decision to treat target, although they are not meeting the 62 day wait target.

The Trust is progressing the requirement to report by equality characteristics measure and the reviewers look forward to this information being available in the next annual report.

Coordination of care/patient pathways

The team are to be commended for their forward thinking approach in having a planning meeting on the Tuesday following SMDT discussion on the Friday, to decide which surgeons will operate on patients and ensure appropriate allocation of resources, for example allocation of operating lists, clinic appointments, depending on the clinical requirements. This ensures a standardised, efficient patient journey.

The CNS communication is good and all CNSs have a meeting every six to eight weeks to look at educational issues and skill mix.

Reviewers were impressed by the nurse led follow up clinics within the local teams. This is to be commended as it reduces travel time for patients who are seen locally.

The network pathology guidelines currently state that the 5th and 6th edition is being used for TNM but the MDT advised that they are using the 7th edition. The network pathology guidelines need to be updated to reflect this change.

There is currently no formal 24 hours surgical cover but the MDT advised that this should be resolved with the planned appointment of two additional consultants. However arrangements should be formalised in the interim period.

The MDT has agreed to the network guidelines for specialist OG cancers.

Patient experience

The team has access to comprehensive and comprehensible information from both local and national sources. The CNSs have been standardising the documentation to ensure that all patients, irrespective of which locality they are from, are given the same information.

A local survey was undertaken in 2010. Of the 130 surveys that were distributed only 56 were returned. Generally the comments received were positive, however, following a negative comment about the distress of a patient who was given their results on a Friday and had to wait over the weekend to discuss them with someone, patients are now given an appointment for the cancer clinic at endoscopy to avoid this occurring in the future.

The surgical team is cohesive and has good professional working relationships to ensure expansion of skills within the clinical team.

Clinical outcomes/indicators

The national data showed that the case ascertainment rate is low, but the MDT advised that this was due to a failure of communication between the responsible trust, with double counting of cases, and the Christie hospital where all neo - adjuvant therapy is performed. Reviewers were advised that this has now been addressed.

The team are to be commended for analysing the 8% of patients in 2010 that did not have histological confirmation of diagnosis. The results showed that many of these patients without histology were elderly frail patients.

Quarter 4 data for 2010/2011 showed that 74% of patients had the stage of their disease recorded.

The team are preforming an appropriate number of resections for the catchment population.

Whilst national figures suggest high re-operative rates and morbidity, reviewers were advised that the data included results from a surgeon who is no longer part of the team and hence it is not reflective of current practice. There had been an issue regarding data submission, as planned interventions are recorded as "returns to theatre", suggesting a higher return morbidity than is the case.

Palliative interventions are increasingly undertaken in the local hospitals with the appropriate expertise.

The length of stay is slightly below the national average for oesophagectomy at 23.5 days but slightly higher for and gastrectomy at 14.5 days (national average is 31 and 9 days respectively)

Figures showing the rates of survival from diagnosis are relatively low which is indicative for the north west of England.

Trial recruitment is poor with only 12 patients being recruited in 2010/11. However, the team acknowledge that they need to increase their levels of recruitment.

Although the team had experienced some issues with data collection they reported improvements have been made over the last 6 months to ensure accurate reporting and data entry.

Good Practice

Good Practice/Significant Achievements

The planning meeting held on a Tuesday following MDT discussion on the Friday ensure clinically appropriate allocation of resources.

Integration of surgeons from Pennine into the specialist team.

Nurse led follow up clinics held closer to home reduces travel for patients.

Concerns

Immediate Risks

Serious Concerns

Concerns

Levels of recruitment into clinical trials are low and need to be enhanced to ensure equity of access.

There is currently no formal 24 hours surgical cover.