



Event commissioned by NHS  
Lanarkshire Cancer Division

‘The Future Provision of NHS  
Lanarkshire Lung Oncology  
Services

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Venue:  
NHS Lanarkshire Monklands  
Hospital Lecture Theatre

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Innovation Department  
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## 1. INTRODUCTION

The Lung oncology stakeholder events on 7<sup>th</sup> May and 4<sup>th</sup> June 2010 were organised by the NHS Lanarkshire Change and Innovation department in conjunction with the Cancer Division lead clinicians and general management. Change and Innovation managers designed the approach for both events to ensure objective development of the programme content; designing structured methodologies to support stakeholders to reach outcomes while ensuring a transparent, rigorous and an auditable process.

This report summarises the second stakeholder event to identify a preferred site for the provision of a single-site, Lung oncology service in Lanarkshire.

## 2. BACKGROUND

Lung oncology services are currently provided on the three acute sites in NHS Lanarkshire. Oncologists are provided by the Beatson West of Scotland Cancer Centre.

NHS Lanarkshire recognises that the current model of care is unsustainable across three sites and, in order to meet the requirements of the West of Scotland Regional Cancer Advisory Group, as set out in the paper '*Specialist oncology service provision across the West of Scotland - implementation of the extant specialist oncology services strategy*'<sup>1</sup>, that a comprehensive service review is required.

In order to meet the requirement for 52 weeks per year access to specialist oncology, consultant-led services, NHS Lanarkshire Cancer Division agrees that a model to deliver specialist Lung Oncology services, on either two sites or one site, must be developed.

### **First Stakeholder Event 7<sup>th</sup> May 2010**

This event builds on the first stakeholder event held on 7<sup>th</sup> May 2010<sup>2</sup>. The first event considered the benefits and disadvantages of the two-site and one-site service models for Lanarkshire. NHS Lanarkshire set out the current service model and service configuration. Stakeholders then explored alternative two-site and a one-site service delivery models, which were set out in the paper '*Review of Lung Cancer Oncology Services in NHS Lanarkshire*' (March 2010).

Either model required NHS Lanarkshire to consider a reorganisation of existing services to determine the most suitable model to deliver specialist Lung Oncology services. The methodology employed enabled participants to objectively consider and score each model against a set of agreed, influencing factors.

The outcome of the scoring exercise was a preference for the one-site model.

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<sup>1</sup> a briefing paper to the Cabinet Secretary for Health and Well Being (October 2009)

<sup>2</sup> The report of the first stakeholder event on 7th May 2010 paper '*Review of Lung Cancer Oncology Services in NHS Lanarkshire*' (March 2010).

At the planning stage for this first stakeholder event it was agreed that the satisfactory confidence margin would be of no less than 10%. Both basic and further analysis of scoring at group and overall levels showed this margin of confidence had been realised.

### **3. EVENT PROGRAMME**

Participants<sup>3</sup> were welcomed by Rhona Robertson, General Manager Cancer Services.

#### **Presentation 1**

Rhona Robertson gave a short presentation on the first stakeholder event, the approach taken and the outcome arrived at. She then described the purpose of this second stakeholder event as a structured approach to examine all the essential, important and desirable characteristics of the service to enable the group to reach agreement on the preferred site for the future delivery of the Lung Oncology service in Lanarkshire. She then explained that this would be a recommendation to be taken forward through the formal structures within NHS Lanarkshire in order to gain approval for implementation.

#### **Presentation 2**

Mr Hakim BenYounes, Clinical Director, gave a verbal presentation that covered the NHS Lanarkshire expectations of the service input from the Beatson West of Scotland Cancer Centre oncologists.

#### **Presentation 3**

Dr David Dunlop, Clinical Director of the Beatson West of Scotland Cancer Centre, gave a presentation that covered the rationalisation of clinics and multidisciplinary teams across the region; sustainable treatment pathways; a team-based approach utilising e-referral and other IT structures; the 31-day decision-to-treatment target; and the need for 52 week per year access to specialist oncology, consultant-led services. Dr Dunlop described a more patient-focussed service; reducing and resolving patient anxieties with no deferred decisions. He noted that less time travelling means more time spent with patients. Dr Dunlop thanked NHS Lanarkshire for providing two clinical scenarios that allowed him the opportunity to respond directly to some of the key concerns of clinicians.

#### **Presentation 4**

John McPhelim, Lead Cancer Nurse Specialist, gave a presentation designed to give stakeholders enough information to inform their decisions in the group work ahead. This covered clinic capacity; clinic requirements; travel for patients across Lanarkshire; co-dependent services; drivers for change including deprivation, co-morbidity, accessibility and transport; and influencing factors such as clinic attendances and stage of presentation for patients by site. All of the information was drawn from local statistics and patient contributions.

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<sup>3</sup> See Appendix 1 for list of participants

#### 4. QUESTION AND ANSWER SESSION

Dr Sam Patel, Consultant Respiratory (Chest) Physician based at Hairmyres Hospital, acknowledged the responses from Dr David Dunlop to the two clinical scenarios provided by NHS Lanarkshire ahead of the event. He then suggested there are other scenarios that demonstrate the benefits of having direct input from oncologists to inpatient care. He described a particular case, which he did not consider to be a one-off example. This was of a 58 year old man with fluid in the chest and lung cancer who four weeks prior to admission was asymptomatic. Dr Patel considered that this patient could not travel by ambulance to see a lung oncologist because he had a chest drain in place and was draining profusely.

Dr Dunlop advised that he has seen many patients in clinics with treatable conditions in similar, even more complicated, scenarios. He suggested that transport to a Lung Oncology clinic by ambulance should be possible.

Dr Patel responded that, even if ambulance transport was possible, it certainly would require more resources to effect. Dr Dunlop suggested that scenarios that require inpatients to be transported by ambulance to Lung Oncology clinics were actually low volume, perhaps less than 5%. Dr Dunlop acknowledged the actual frequency was probably about one patient per site per month, but reiterated that the core service should be designed around the much bigger patient group. However, he gave an assurance that oncologists would still cover inpatients with treatable conditions that were not able to be transported by ambulance to Lung Oncology clinics.

Dr Hazel Scott, Consultant Respiratory (Chest) Physician based at Wishaw General Hospital, raised a number of matters for discussion.

- Chest physicians value the helpful relationships that currently exist with oncologists. More discussions are needed about how face-to-face contact can be maintained between local multidisciplinary teams and oncologists. Consideration could perhaps be given to a system of oncologist rotation.
- With travel issues in mind, chest physicians have concerns about how chemotherapy is delivered within the new service model.
- Again with transport by ambulance in mind, the aim should be that arrangements are good rather than just feasible.

Dr Dunlop first responded to the matter raised about the benefits of face-to-face contact with oncologists. Experience elsewhere has shown that communication with an oncologist who appears on a screen rather than face-to-face should not make a big difference.

Dr Scott felt that it would make a difference because face-to-face meetings allow the chest physician and the oncologist to get to know each other and get a feel for the way the other works. Dr Dunlop suggested the key question is whether not having face-to-face meetings will result in wrong decisions being taken. Dr Scott felt there may be a risk of this happening. Dr Dunlop advised that oncologists working at the Beatson WoS Cancer Care Centre currently take part in 22 multidisciplinary meetings across the region using video conferencing links. So far, there has been no feedback that would suggest there has been any negative impact from this way of working.

Dr Dunlop then responded to the matter raised about the delivery of chemotherapy within the new model. The important issue is that it is the consultant oncologist that initiates the treatment plan to deliver chemotherapy, while it is for others to decide where the chemotherapy will be delivered.

Dr Dunlop then responded to the matter raised about ambulance transport. He reiterated the point made earlier that this is a low volume group of patients, but agreed that transport arrangements should be to an appropriate standard agreed with the Scottish Ambulance Service.

The session concluded with a suggestion from Mr Ali Jilaihawi, Consultant Thoracic Surgeon about the potential benefits of co-locating Thoracic Surgery and Lung oncology clinics. Mr Hakim BenYounes agreed that this should be considered as part of this redesign process and further discussions in relation to would indeed take place.

## **5. GROUP WORK**

Participants were then allocated to one of three groups. Each group considered a number of characteristics of a Lung oncology clinic to enable a decision to be made on the preferred site. These characteristics were considered to be either essential or desirable or important to service provision.

Each group first worked through the essential characteristics. Following a discussion about each characteristic, the participants used recording sheets to indicate which of the three hospital sites they considered were able to deliver against that particular characteristic. This process was then repeated for the important characteristics and then again for the desirable characteristics.

**Essential characteristics** considered were:

1. Patient centred in terms of hospital located close to population with greatest need
2. Patient-centred in terms of minimising travel distance and journey times for patients
3. Accessible in terms of co-morbidity of patient population
4. Quality service in terms of meeting demand and need, and delivering best patient outcomes

**Important characteristics** considered were:

1. Availability in terms of co-dependent services (Respiratory and Specialist Nursing)
2. Accessible in terms of good public transport links to all sites
3. Opportunities for integrated care with the planned location of the Maggie's Centre (bricks and mortar)
4. Opportunities for integrated care with planned location of Cancer Centre (virtual)
5. Accessible in terms of available patient parking close to clinic
6. Best fit in terms of minimising disruption to other specialties

**Desirable characteristics** were:

1. Accessible and patient-centred in terms of co-dependent outpatient services (Audiology, Cardiology and ENT)
2. Accessible in terms of accommodating to 'rural and remote' travelling patients
3. Quality service in terms of providing dedicated, comfortable and patient-friendly waiting area

## 7. ANALYSES AND RANKING

As described earlier, within their respective groups participants used recording sheets to indicate which of the three hospital sites they considered were able to deliver against that particular characteristic. At the conclusion of the group work, the individual scores for each group were aggregated by the respective facilitators. The group scores were then transferred to a master score card and aggregated to give the overall final rankings.

At this stage, in terms of methodology, there were a number of planned steps.

### Step 1

Consider if a clear preference emerges after consideration of the feedback on **essential** characteristics. If there is, then there is no requirement to proceed further. If there is not, move to Step 2.

### Step 2

Consider if a clear preference emerges after consideration of the feedback on **important** characteristics. If there is, then there is no requirement to proceed further. If there is not, move to Step 3.

### Step 3

Consider if a clear preference emerges after consideration of the feedback on **desirable** characteristics. If there is, then there is no requirement to proceed further. If there is not, move to Step 4.

### Step 4

There is no Step 4!

## The Outcomes

### Essential

Scores	Hairmyres				Monklands				Wishaw			
	G1	G2	G3	ALL	G1	G2	G3	ALL	G1	G2	G3	ALL
Actual	19	6	6	<b>31</b>	36	31	22	<b>89</b>	36	25	26	<b>87</b>

There was no clear preference between Monklands and Wishaw at this point with only two points separating these sites. However, Hairmyres was eliminated.

### Important

Scores	Hairmyres				Monklands				Wishaw			
	G1	G2	G3	ALL	G1	G2	G3	ALL	G1	G2	G3	ALL
Actual	34	27	25	<b>83</b>	39	33	36	<b>108</b>	31	26	35	<b>92</b>

At this point the 16 point gap between Monklands and Wishaw was considered sufficient to conclude there was a clear preference for Monklands.

**Desirable**

Scores	Hairmyres				Monklands				Wishaw			
	G1	G2	G3	ALL	G1	G2	G3	ALL	G1	G2	G3	ALL
Actual	19	21	15	55	20	20	20	60	22	21	24	67

**8. CONCLUSION**

The outcome was to recommend Monklands District General Hospital as the preferred site for the provision of Lung Oncology clinics for NHS Lanarkshire.

**9. EVENT EVALAUTION**

Eighteen people returned evaluation forms. The points noted in the returns rated the following areas: the venue, hospitality, all presentations, and the format of group discussions. The majority of the returns rated the format good to very good with a few people noting that opportunity to ask questions and take part was poor. A high number of returns rated the venue and hospitality very good to good with a few rating the venue and the lunch poor.

**Patient feedback**

- “A good opportunity to hear staff views and important discussions for patients.”*
- “Required more time for group discussion.”*
- “Found the event quite personal, gained a lot of knowledge and understanding of the workings of the hospital.”*
- “Much more emphasis on patient care and comfort this time – which is the underling concern of the exercise.”*

**Staff feedback**

- “Not enough information to make decisions.”*
- “Felt the process was rushed with insufficient time for questions after each presentation.”*
- “No data sent out prior to the meeting.”*
- “Perhaps not the most appropriate tool for determining the outcome of this service configuration.”*
- “Time was tight, however focussed discussion and good facilitation ensured protracted discussions did not happen. A significant amount of work has gone into this.”*

**10. NEXT STEPS**

Rhona Robertson brought proceedings to a close by thanking everyone for their views, ideas and suggestions. She confirmed that the outcomes would be validated and further analysed by the Change and Innovation team. Rhona reiterated that the recommendation for Monklands as the preferred site would be taken forward through the relevant committee structures to gain approval and to plan for implementation.

## APPENDIX

### Participants

	Title	First Name	Surname	Designation	Group
1.	Dr	Stuart	Baird	Consultant Respiratory Physician	1
2.	Mr	Hakim	BenYounes	Lead Clinician, Cancer Services	1
3.	Ms	Kirsty	Bridges	Lung CNS	1
4.	Mr	Tony	Fitzpatrick	Facilitator	1
5.	Mr	Bernard	Gallagher	Patient representative	1
6.	Mrs	Carol	Gallagher	Patient representative (spouse)	1
7.	Miss	Ann	Graham	Patient representative	1
8.	Mr	Gary	Jenkins	General Manager, Beatson WoS Cancer Centre	1
9.	Mr	Ali	Jilaihawi	Consultant Thoracic Surgeon	1
10.	Mr	Colin	Lauder	Head of Modernisation	1
11.	Mr	Barry	Moore	Patient representative (nephew)	1
12.	Dr	Sam	Patel	Consultant Respiratory Physician	1
13.	Mr	Maurizio	Puricelli	Patient representative	1
14.	Mr	Danny	Rankin	Clinical Service Manager	1
15.	Mr	Tom	Sim	Business Support Manager	1
16.	Dr	Andrew	Smith	Consultant Respiratory Physician	1
17.	Ms	Kate	Bell	Facilitator	2
18.	Dr	David	Dunlop	Clinical Director, Beatson WoS Cancer Centre	2
19.	Dr	Barbara	Hamilton	Consultant Radiologist	2
20.	Dr	Lawrence	McAlpine	Consultant Respiratory Physician	2
21.	Mr	Craig	McKay	Communications Team	2
22.	Mr	John	McPhelim	Lead Lung Cancer Nurse	2
23.	Mr	Joe	Naismith	Patient representative	2
24.	Mrs	Margaret	Naismith	Patient representative (spouse)	2
25.	Dr	Hazel	Scott	Consultant Respiratory Physician	2
26.	Ms	Mhairi	Simpson	Nurse Consultant, Cancer Services	2
27.	Dr	Raheel	Syyed	Consultant Respiratory Physician	2
28.	Mrs	Kath	Franchitti	Management Accountant	3
29.	Ms	Marianne	Hunter	Partnership Representative	3
30.	Ms	Lynn	Irvine	Lung CNS	3
31.	Ms	Debbie	Marklow	Local Officer, Scottish Health Council	3
32.	Ms	Faith	McCrea	Facilitator	3
33.	Mr	John	Milne	Lead Pharmacist	3

34.	Ms	Marysia	Morkis	Communications Team	3
35.	Ms	Ann	Muir	PPF representative	3
36.	Dr	Manish	Patel	Consultant Respiratory Physician	3
37.	Mrs	Rhona	Roberton	General Manager, Cancer Services	3
38.	Mr	James	Rossiter	Patient representative	3
39.	Mrs	Sheila	Rossiter	Patient representative (spouse)	3
40.	Dr	Soong	Tan	Consultant Respiratory Physician	3
41.	Ms	Janet	Tillman	Top Grade Biochemist	3
42.	Mrs	Elizabeth	Urquhart	Patient representative	3

Group	Leads	
1	Dr Hakim Ben Younes	Clinical Director Cancer Services
2	John McPhelm	Lead Lung Cancer Nurse
3	Rhona Roberton	General Manager Cancer Services Division

Group	Facilitators	
1	Tony Fitzpatrick	Change and Innovation Manager
2	Kate Bell	Change and Innovation Manager
3	Faith McCrea	Service Improvement Manager

Thank you to Lorraine Forrest, Projects Officer Change and Innovation department and Kirsty Norwood PA to General Manager Cancer Services who worked very hard to co-ordinate the invites and prepare the papers for both events.

Copies of this report and the presentations from the event can be accessed at the Change & Innovation Department FirstPort site. Click [here](#) to access.

**For further information on this report contact:**

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