



‘The Future Provision of Lung Oncology Services in NHS Lanarkshire’

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2010

Venue: NHS Lanarkshire
HQ Hamilton

Event commissioned by NHS Lanarkshire Cancer Division

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NHS Lanarkshire Change & Innovation Department

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Quality Improvement based on the Dimensions of Care:



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1. BACKGROUND

This report summarises the stakeholder workshop for lung oncology services in Lanarkshire.

The workshop was arranged by NHS Lanarkshire Cancer Division in response to the West of Scotland Regional Cancer Advisory Group (WoSRCAG) paper '*Specialist oncology service provision across the West of Scotland - implementation of the extant specialist oncology services strategy*', a briefing paper to the Cabinet Secretary for Health and Well Being (October 2009).

The WoSRCAG paper recommends that NHS Lanarkshire lung oncology services would reduce from a three-site service to a maximum two-site service. The engagement process is consistent with the CEL 4 (2010) '*Informing, Engaging And Consulting People In Developing Health And Community Care Services*' guidance. The workshop also proceeded on the basis of consultation by Mr Robert Calderwood Chief Executive NHS Greater Glasgow and Clyde with colleagues in the Scottish Government Health Department and thereafter with the Cabinet Secretary. NHS Lanarkshire received confirmation from Mr Calderwood on 12th April 2010 that "*the Cabinet Secretary is content that we proceed to implement the changes in cancer services along the lines of the FRMC Report 2002.*" The Cancer division in Lanarkshire agreed to proceed with clinicians and other key stakeholders across the Board area.

NHS Lanarkshire set out the current service model and service configuration, and also explored alternative service models, set out in the paper '*Review of Lung Cancer Oncology Services in NHS Lanarkshire*' (March 2010).

The alternatives examined in this paper are a two-site and a one-site service delivery model. Either model requires NHS Lanarkshire to consider a reorganisation of existing services to determine the most suitable model to deliver specialist lung oncology services.

Participants in the stakeholder event received copies of both papers as background information ahead of the event.

2. CURRENT SERVICES

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

NHS Lanarkshire recognises that the current model of care is unsustainable across three sites and, in order to meet the requirements set out above, a comprehensive service review is required. NHS Lanarkshire Cancer division agrees that, in order to meet the requirement for 52 weeks per year access to specialist, oncology consultant-led services, a more suitable model to deliver specialist lung oncology services on a two-site or one-site model must be developed.

3. EVENT PROGRAMME

Participants¹ were welcomed by Rhona Robertson, General Manager Cancer services.

¹ See Appendix 1 for list of participants

Rhona opened the event by giving a short presentation that outlined the background to the current change process. She described the purpose of the stakeholder event as a process to examine and agree the service model in consideration of the merits of either a two-site or one-site model.

3.1 Presentations

Mr Hakim Ben Younes, Clinical Director gave a presentation that put the stakeholder event in the context of the services that are being delivered from the Beatson West of Scotland Cancer Centre and the West of Scotland Cancer Network Strategy. He gave an overview of the specialist lung cancer pathway, the existing pathways for the three acute sites in Lanarkshire, current utilisation across all sites in the West of Scotland, first treatment options and the different treatment options for patients with lung cancer. Mr Ben Younes highlighted the fact that changes to wider services in Lanarkshire would be minimal and the move to a two- or a one-site model for oncology clinics will only improve services to patients.

The significant changes according to Mr Ben Younes were as follows:

- Rationalisation of clinics and multidisciplinary meetings across the West of Scotland region
- Move towards a position of consultant-led services
- Sustainable treatment pathways
- A team-based approach utilising e-Referral and other IT structures

John McPhelim, Lead Lung Cancer Nurse gave a presentation covering the internal and external drivers for change in relation to the future proposals for lung oncology service delivery. This comprehensive presentation was a distillation of the aforementioned reports covering: the potential of each model; data on epidemiology, deprivation and mortality rates; issues of co-dependence; and patient and staff perspective, as captured in the independent analysis carried out by the Patient Experience Programme '*Better Together*' in February/March 2010.

3.2. Drivers for Change

The following drivers for change were considered in the groupwork discussions:

- Ensuring Lung Cancer Oncology services are patient focussed
- Complying with WoSRCAG, briefing paper outlining specialist oncology services for the West of Scotland
- Meeting the requirements of the FRMC report 2002²
- The requirement to collaborate with the Beatson West of Scotland Cancer Centre, in delivering sustainable cancer services
- Developing services that are equipped and responsive to changing treatments and complexity of treatments
- Complying with HEAT target A9³, in relation to treatment targets

² previously referred to as the Beatson Redesign

³ From the quarter ending December 2011, 95 per cent of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95 per cent of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.

- Possible opportunity to consolidate thoracic surgical services in NHS Lanarkshire
- The need for 52 week/year access to specialist oncology consultant-led services
- Fulfilling capacity for new cancer patient appointments
- Increasing flexible/part time consultant workforce in medical and clinical oncology
- Seeing more patients, treat more patients, and manage more complex radiotherapy
- Responding to the increasing requirement for training of junior staff and the educational assessments this requires
- A 31 day decision-to-treat to treatment waiting time target, in line with the local delivery plan
- Impending restrictions on numbers and duties of specialist registrars who are used to 'deputise' during consultant absences

4. APPROACH AND METHODOLOGY

The stakeholder event involved inviting representatives identified through the Clinical Divisional Management Team from across a range of key staff groups, as well as patient representatives and individual service users and carers to consider the merits and qualities of the proposed models of service.

In line with the guidance contained within the short life working group report '*Making Difficult Decisions in the NHS in Scotland*' (March 2010), the challenge was to ensure the decision-making process was reasonable, transparent and justifiable. The report states that "*the reasons for decisions must be based on evidence, reasons and principles that all fair-minded parties (managers, clinicians, patients, and consumers in general) can agree are relevant to deciding how to meet the diverse needs of a population.*" The influencing factors used in the group work session were based on The Institute of Medicine '*Six Dimensions of Care*'⁴, which remain a key foundation of the NHS approach to systems-based, healthcare quality improvement.

Participants were divided into three facilitated groups and asked to assess, in a structured way, the proposed models, as described below.

5. FACILITATED GROUP WORK

5.1 Groupwork - Part I

This facilitated session captured participants' views about the two proposed models. The areas for consideration were:

- Benefits
- Disadvantages
- Risks and how these may be mitigated
- Challenges to implementation
- Opportunities for further modernisation and improvement

⁴ In 2001, the [Institute of Medicine](#) outlined six Aims for Improvement for health care in their report, "Crossing the Quality Chasm: a New Health System for the 21st Century."

As the requirement was to deliver the service on fewer than three sites, both a two- and a one-site model would comply with the Regional Cancer Advisory Group recommendations. Both models also deliver a consultant-led service i.e. with no reliance on trainees, a team approach to chemotherapy and timelier planning of patient care and treatment. The new model of care and service configuration will also enhance patient-centred care by providing a higher frequency of contact with oncologists in Lanarkshire and will enable a more integrated and holistic approach. It was noted in more than one group that parking at the hospital sites in Lanarkshire can be problematic.

5.2. Groupwork Feedback

In three separate groups participants discussed the benefits, disadvantages and risks of each model and, time permitting, challenges to implementation and opportunities for further modernisation and service improvement.

The next part of this report provides a summary of the output from across the three groups.

5.2.1. Two-site model

Benefits

- 52 week per year oncology cover (excepting clinical oncology)
- Likelihood of 'single consultant' supported services is reduced to 15% (approx)
- Concentration of oncology skills and expertise on two sites
- Delivers a consultant-led service that improves decision making
- Condensed consultant care-giving with a benefit to the patient
- Images/case notes/other clinicians more likely to be on the same site as patient
- Preservation of close respiratory/oncology relationship
- Opportunity to utilise more efficiently the specialist lung cancer nursing skills and knowledge
- Oncology skills and expertise on two sites
- Consistency also around Oncology and oncology

Disadvantages

- The one site with no oncology input may be disadvantaged. There are considerable quality issues in respect to the inpatient and day workload including pharmacy issues and being able to access an oncologist.
- There will be increased demand on the available clinical space on the two sites chosen, though there will be an associated reduced demand on the third site. Need to consider what might get displaced and to where (implications for consultant job plans).
- A number of patients will have to travel further to access a clinic. This will depend on the sites chosen.
- Additional pressures on the Patient Transport Services/Scottish Ambulance Service.
- Multidisciplinary team meetings will be longer and more challenging because of that.
- This model will not provide clinical oncology 52 weeks per year.

Risks and how these might be mitigated

- There is an inherent risk associated with the transfer of patient data and information, including case records between sites. This risk could be mitigated with the implementation of a new Patient Management System (PMS) and by rolling out initiatives that have proven to be successful for other services e.g. patient held records.

- Increased journey times and distances may lead to an increase in patients not keeping clinic appointments i.e. DNA⁵ rates may increase. This risk might be mitigated by implementing a range of initiatives that have successfully reduced DNA rates for other services.
- Delays for patients on the site with no oncology could be overcome through strong team work, robust communication and co-operation. Also all information could be kept on secure database available to all 3 sites. Designated visit days for patients may address the uncertainty of In Patient reviews.
- Clinicians on the site that does not have Oncology clinics may become de-skilled over time. This risk might be mitigated through the development of sub specialisation (though could not happen in isolation from other services), staff rotation and links into multidisciplinary teams.
- Current Radiology capacity has an impact on current waiting time targets. Any risk of not meeting waiting time targets may be mitigated by increased and protected Clinical Oncology cover, backed up by Radiology capacity at the Beatson WoS Cancer Care Centre.
- The loss of continuity of care for patients with so many appointments. With good communication of rationale (safety/expertise) this would be understood by patients and staff.
- The availability of notes and case notes missing notes will present as a risk however with the electronic patient record due to be implemented in September 2010 this will be reduced and eventually eradicated. Increased use of IT systems in MDT's will also assist.
- The lack of space on our hospital sites may present issues which can only be addressed through an increased capacity in out patients by moving other specialties.
- The failure of Video Conferencing equipment has been identified as a risk high risk and could be mitigated by higher frequency use and communication of successes whilst ensuring technology always operational through good maintenance programme.
- The need for patients to travel is an issue and can only be addressed through increased availability/capacity of SAS Patient transport service and good sign posting to alternatives for those fit enough to travel independently.

5.2.2 One-site model

Benefits

- 52 week per year oncology cover (including clinical oncology).
- Potential to attract specialist services into Lanarkshire therefore treating and supporting more patients locally.
- Consultants from all three sites will take part in multidisciplinary team meetings.
- Co-location of disciplines and concentration of expertise will lead to better team working and organisation of service, as well as more stable and effective infrastructure.
- Opportunity to utilise more efficiently the specialist lung cancer nursing skills and knowledge and improved representation and access to palliative care services
- Fits with Cancer Centre philosophy and would allow sub specialty expertise to develop
- Single point of contact for patients as well as clinicians
- Availability of more clinic appointments
- More timely planning of patient care and treatment

⁵ DNA – Did Not Attend

Disadvantages

- The two sites with no oncology input may be disadvantaged. There are considerable quality issues in respect to the inpatient workload including being able to access an oncologist.
- There will be increased demand on the available clinical space on the chosen site (significantly more than the two-site model), though there will be an associated reduced demand on the other two sites. Need to consider what might get displaced and to where (implications for consultant job plans).
- A number of patients will have to travel further to access a clinic (significantly more than the two-site model). This will depend on the sites chosen.
- Additional pressures on the Patient Transport Services/Scottish Ambulance Service (significantly more than the two-site model).
- Multidisciplinary team meetings will be longer (even more so than for the two-site model) and more challenging because of that.

Risks and how these might be mitigated

- There is an inherent risk associated with the transfer of patient data and information, including case records between sites. The risk would be greater than for the two-site model. This risk could be mitigated with the implementation of a new Patient Management System and rolling out initiatives that have proven to be successful for other services e.g. patient held records.
- Increased journey times and distances may lead to an increase in patients not keeping clinic appointments i.e. DNA rates may increase. The risk would be greater than for the two-site model. This risk might be mitigated by implementing a range of initiatives that have successfully reduced DNA rates for other services.
- Clinicians on the sites that do not have oncology clinics may become deskilled over time. This risk might be mitigated through the development of sub specialisation (could not happen in isolation from other services), staff rotation and links into multidisciplinary teams.
- Insufficient radiology capacity is the most common cause of NHS Lanarkshire 'breaches'. The risk of breaches might be mitigated by increased and protected clinical oncology cover, backed up by radiology capacity at the Beatson West of Scotland Cancer Care Centre.
- Inherent delays in organising diagnostic tests across sites
- The availability of medical records would be an increased risk as transfer would happen more frequently. It was recognised that proposed IT improvements would mitigate this risk in future.
- Respiratory department will be required to admit more cases
- Poor referral pathways, poor video conferencing equipment and poor communication could hamper this model. It is recognised that the implementation of the electronic patient record and further development of video conferencing, as well as clear protocols (to be developed), further development of IT resources and infrastructure, will overcome this in time.
- Inpatients on two sites at risk of delayed decisions. This can be mitigated through dedicated days for inpatient visits – could best be delivered if respiratory services were on one site
- The issue of outpatient space will only be mitigated/overcome through good capacity planning and ensuring all specialties and site demand is considered

Due to time constraints, not all groups went on to consider the possible challenges to implementation and opportunities for further modernisation for these models. However, all groups agreed the importance of having a more detailed discussion about challenges to implementation and opportunities for modernisation (such as securing adequate clinical space to hold clinics) at the beginning of the next event on 4th June 2010.

Challenges to implementation (most common to both two-site and one-site model)

- Clinic capacity and the physical space in outpatient departments is a major challenge to implementation of this model
- A change to job plans
- Lack of clinical cooperation
- Support services – Scottish Ambulance Service/Patient Transport Service
- Patients missing and/or delaying clinic appointments owing to travel demands
- Logistics, timing and organisation of change
- IT infrastructure and resources to support the one-site model – centre of excellence
- Cost to make improvements happen

Opportunities for further modernisation and improvement (common to both two-site and one-site model)

- Opportunity to get ideal dedicated, quiet area for patient-centred clinic space
- Will encourage opportunities to undertake research and participate in trials

5.2 Groupwork - Part 2

Each group then proceeded to consider the extent to which each model would deliver against 10 factors, which had been identified and ranked by the operating division as being important to service delivery.

Each group then considered each of the 10 factors in turn, including how these might be defined. Working through the list of factors, individuals scored each factor on a scale of 0-10 for the two-site and then the one-site model.

The scores from each group were then collated and the weightings of the factors were then applied. This process enabled the one-site model to be identified as the preferred model.

The weightings applied to the factors, which were determined by a separate process ahead of the stakeholder event, were as follows:

Table 1

FACTORS	Weighting	FACTORS	Weighting
Patient Centredness	2.0	Availability/Accessibility	1.5
Quality	2.0	Standards and measures	1.2
Communication	1.8	IT systems & technology	1.0
Staffing	1.7	Specialty structure	0.8
Sustainability	1.5	Development/Improvement	0.5

6. ANALYSING AND SCORING THE MODELS

6.1 The outcomes

A total of 27 individuals participated in the scoring exercise.

Each individual scored the options on a scale of 0-10 using a scoring sheet that had been designed for the purpose i.e. a matrix showing both the options to be scored and the factors against which each option would be considered.

The individual scores for each group were transcribed onto a master score card by the group facilitators. This allowed the pre-determined weightings of the factors to be applied and a final score to be calculated. The final scores from group master score cards were then aggregated to give the overall final ranking of the two options.

Both the individual scoring sheets and the group master score cards have been retained for the purpose of audit. The scores came out as follows:

Table 2

Group	No. of Scorers	Two-Site	One-Site
Group 1	10	745	872
Group 2	9	836	1004
Group 3	8	663	750
Overall	27	2,244	2,626

Basic analysis of the scoring shows that:

- 25 out of 27 scorers indicated a preference for the one-site model
- 3 out of 3 groups indicated a preference for the one-site model.
- The margin of difference between the scores were - Group 1 (15%), Group 2 (17%), Group 3 (12%) and Overall (15%).

Further analysis with the two highest and two lowest (outlying) scorers⁶ removed to reduce the possibility of bias was carried out. This shows that:

- 23 out of 23 scorers indicated a preference for the one-site model
- 3 out of 3 groups indicated a preference for the one-site model.
- The margin of difference between the scores were - Group 1 (11%), Group 2 (14%), Group 3 (14%) and Overall (13%).

At the planning stage for this event it was agreed that a satisfactory confidence margin would be of no less than 10%. Both basic and further analysis (with outlying scorers removed) of scoring at group and overall levels shows this margin of confidence has been realised.

6.2 Plenary session

The scores for each of the groups (table 2) were presented to the main group in the plenary session. Some discussion took place regarding what the preferred option would mean in terms of capacity, relationships and collaborative working with the WOSCC and also for patients. Comments were also received at this time relating to the work that will need to be done to

⁶ Scorers 8, 16, 19 & 23

deliver ahead of the a one-site model and also with the West of Scotland Cancer Centre (WOSCC) on what this model will mean for provision of sessions by the WOSCC.

7. EVALAUTION

Seven people returned evaluation forms. Overall, presentations were well received (noted as very good or good). A few individuals commented that the visibility of the presentation handouts was poor and that this impacted on the ability to see the detail of the content. The comments on the venue ranged from good to very poor. One individual described the discussion as “rushed.” One patient representative noted that the event was “a good opportunity to discuss not only patients views (*but*) for me to hear the staff views”.

8. NEXT STEPS

A further stakeholder meeting will be held 4th June 2010 to decide which site is most appropriate to deliver the lung oncology service. Rhona Robertson brought proceedings to a close by thanking all participants for their views, ideas and suggestions and confirmed that these would also be taken forward into the next stakeholder event.

9. EQUALITY AND DIVERSITY

NHS Lanarkshire is committed to equality and diversity. To ensure this we have undertaken an Equality and Diversity Impact Assessment.

Appendix 1 Participants

	Title	First Name	Surname	Designation	Group
1.	Mrs	Marion	Mark	Divisional General Manager Womens and Diagnostics Division	2
2.	Ms	Kirsty	Bridges	Lung CNS	1
3.	Ms	Eileen	Clarke	Senior Nurse for Women's, Children's Cancer and Diagnostic Division	1
4.	Dr	Kenneth	Dagg	Consultant Respiratory Physician	1
5.	Mr	Bernard	Gallagher	Patient representative	1
6.	Mrs	Carol	Gallagher	Patient representative (spouse) (did not attend)	1
7.	Dr	Barbara	Hamilton	Consultant Radiologist	2
8.	Ms	Marianne	Hunter	Partnership Representative	3
9.	Ms	Lynn	Irvine	Lung CNS	3
10.	Mr	Ali	Jilaihawi	Consultant Thoracic Surgeon	1
11.	Ms	Debbie	Marklow	Scottish Health Council	3
12.	Dr	Lawrence	McAlpine	Consultant Respiratory Physician	2
13.	Mr	Craig	McKay	Communications Team	2
14.	Mr	John	McPhelim	Lead Lung Cancer Nurse	2
15.	Mr	John	Milne	Lead Cancer Pharmacist	3
16.	Ms	Ann	Muir	PPF representative	2
17.	Mr	Joseph	Naismith	Patient representative (<i>Could not attend</i>)	2
18.	Mrs	Margaret	Naismith	Patient representative (spouse) – (<i>could not attend</i>)	2
19.	Dr	Manish	Patel	Consultant Respiratory Physician	3
20.	Dr	Sam	Patel	Consultant Respiratory Physician	1
21.	Mr	Danny	Rankin	Clinical Service Manager	1
22.	Mr	James	Rossiter	Patient representative	3
23.	Mrs	Sheila	Rossiter	Patient representative (spouse)	3
24.	Dr	Sudipta	Roy	Consultant Respiratory Physician	3
25.	Dr	Hazel	Scott	Consultant Respiratory Physician	2
26.	Mr	Tom	Sim	Business Support Manager	1
27.	Ms	Mhairi	Simpson	Nurse Consultant, Cancer Services	2
28.	Dr	Andrew	Smith	Consultant Respiratory Physician	1
29.	Ms	Susan	Stewart	Associate Director of Nursing & Midwifery	3
30.	Dr	Soong	Tan	Consultant Respiratory Physician	3
31.	Dr	Raheel	Syyed	Consultant Respiratory Physician	2
32.	Dr	Fiona	Gardiner	Consultant Radiologist	3
33.	Dr	Stuart	Baird	Consultant Respiratory Physician	1

Group	Leads	
1	Dr Hakim Ben Younes	Clinical Director Cancer Services
2	John McPhelim	Lead Nurse Cancer Services
3	Rhona Robertson	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

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

- Specialist oncology service provision across the West of Scotland - implementation of the extant specialist oncology services strategy”, a briefing paper to the Cabinet Secretary for Health and Well Being (October 2009).
- Review of Lung Cancer Oncology Services in NHS Lanarkshire’ March 2010.

References and notes

Event Presentations by
 Rhona Robertson General Manager
 Mr. Hakim Ben Younes Clinical Director Cancer Services
 John McPhelim Lead Nurse Cancer Services

- Making Difficult Decisions in NHS Boards in Scotland March 2010
 NHS Quality Improvement Scotland <http://www.nhshealthquality.org/nhsqis/7879.html>
- CEL 4 (2010) *Informing, Engaging and Consulting People In Developing Health And Community Care Services*
- Institute of Medicine – Six Dimensions of Care – NHS Quality Improvement Scotland
- NHS Lanarkshire Local development Plan 2010/11

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