



Shaping the Future of Northern Ireland Chemotherapy Services

Summary of Workshop
11th June, 2010

**The contents of this document simply reflect the workshop discussions.
To ensure transparency the data has not been themed or altered in any way.**

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1.0 WORKSHOP AIMS

- Feedback on the NICaN regional chemotherapy baseline assessment
- Learn from experience elsewhere
- Consider options for future chemotherapy services
- Inform key actions

2.0 WORKSHOP PROGRAMME

Chairman's Opening Remarks	Mr John Compton Chief Executive HSCB
Session One: Hearing from others	
NICaN Chemotherapy Service Review Project	Dr Robert Harte Consultant Clinical Oncologist, Chair of Regional Chemotherapy Review
Quality & Safety in Chemotherapy Services: A National Perspective and Regional Experience	Dr Peter Clark Consultant Medical Oncologist, Clatterbridge: Co Chair NCAG & Chair NCIG
Chemotherapy Models: The Pros and Cons	Dr David Dunlop Clinical Director, Beatson, West of Scotland Cancer Centre
Questions	
Session Two: Having your say	
Issues for Consideration	Dr Martin Eatock Consultant Medical Oncologist, Cancer Centre Chemotherapy Lead, Chair NICaN D&T
Workshop	Mrs Liz Henderson Network Nurse Director
Panel Discussion	
Closing Remarks – Next Steps	Dr Robert Harte

3.0 WORKSHOP ATTENDEES

The following stakeholder groups were represented across Trusts:

- Patient Public Involvement Reps
- DHSSPS
- Patient Client Council
- Consultant Medical Staff
- Executive & Co Directors
- Service Managers
- Senior Cancer Nurses
- Chemotherapy Nurses
- Clinical Trials
- Regional HSC Board
- Public Health Agency
- Cancer Charities
- LCG Chair
- General Practitioners
- Pharmacy Director / Managers
- Pharmacists
- Allied Health Professionals
- NICaN Team

See Appendix 1 (page 20) for a complete delegate list.

4.0 FEEDBACK FROM WORKSHOP SESSIONS

Participants were seated in groups of 10 at 7 tables. Each table had a facilitator and a note taker. Proformas were completed to reflect group discussion and were collated at the end of the workshop.

The aims of this particular session were to:

- To achieve a common understanding of the principles underpinning potential service development
- To test the validity of the working assumptions
- To get a sense of the preferred options

The following section is a summary of the discussions.

4.1 Exercise One: Understanding of Underpinning Commissioning Principles

Attendees were asked to consider the interpretation of the underpinning commissioning principles to see if they reflected their understanding.

1. Patients are able to access quality services and patient experience is good
2. Services are delivered safely
3. Treatments which are delivered are appropriate to the patient's condition
4. Services are convenient for patients
5. Services represent good value for money

1. Patients who might benefit from chemo are able to access **quality** service and patient **experience is good**. This means there will be:

- No undue delay
- Assessment will take into account the holistic needs of the individual
- Services and teams will be designed around patients needs
- The provision of information and support is integral
- There will be equity with regards to standard of service and access to chemotherapy drugs

Comments:

Current emphasis on delays at start and not further in the pathway

Access targets dominate but issues for pts re recurrence and reviews need attention

Equity is most important word

Have to be seen within resources available and those with resource responsibility have duty of care

Commissioners have not always witnessed use of resources applied in the way prescribed "therapeutic creep"

Patient demands are taken into account too much rather than population need

Can't only be around patients entire needs; it must be in the context of the Network e.g. cannot give everyone chemo at home.

What patients may think will be a good experience for them may not turn out to be in terms of their actual experience.

Real issue not addressed, clinical freedom can result in taking from someone else

Needs identified need to be met

Need to manage expectations

No undue delay is a meaningless phrase, say 'timely access to treatment'

Should say 'as good as possible'

Patients need to understand the process

Patients need education re timely delay, timely access and need to be adequately informed about the service

Are there bottlenecks in the service that could be addressed?

2. Services are delivered **safely**

- Governance arrangements will be in place
 - Risk management etc.
- Workforce
 - Knowledgeable / skilled
- Processes and systems
 - Clear patient pathways
 - Clear information exchange

Comments:

Services need to be sustainable and reproducible

More money is spent counting what we do rather than on what we do

Distributing resources well is so important

There is inappropriate use sometimes

No formal governance arrangements

Governance arrangements / Consultants are accountable to Cancer Centre but not to Cancer Units

Shared governance across the individual organization boundaries need to be clarified

Morbidity and mortality meetings should occur

Need to ensure input into weekly Morbidity & Mortality meetings

Clear patient pathways required

How far does workforce extend?

There is a need to ensure clear communication pathways between Oncologists, Haematologists and other medical teams who may be involved in the care of their patients

3. Treatments which are delivered are **appropriate** to a patient's condition

- Evidence based / clinically effective
- Clinical assessment / performance status
- Changing treatment intent fully communicated to patient across the pathway

Comments:

Clinical Management Guidelines need to be adhered to

Standardisation of CMG and chemo protocols

Communicating intent of treatment at beginning, to patient, GPs and shared widely across team, changes to intention of treatment communicated in same way

Repeat assessment will take into account individual needs identified

Need to add appropriate to patients outcome of care

Patient expectation

Decision should be taken by appropriately constituted MDMs and local MDMs. Vitaly important that Oncologists and Haematologists arte able to attend

4. Services are **convenient** for patients

- Elements of treatment delivered locally where possible

Comments:

Timing of delivery, Consistency of Service

Tiering of service

Where possible if it is the right thing to do

Value for money

Patient Centred

Critical mass re skills

Issues of consultant sub specialty

From WHSCT perspective there needs a lot more local services and communication link currently not strong

Convenient is not the word – we need to talk about the service, ie is it 120 miles for a blood test not appropriate but maybe ok to travel that distance for complex treatment

Patient expectation

Acceptance current delivery can change, but it might increase the cost if treatment is given to patient nearer to home

5. Services represent good **value for money**

- Most cost effective way of doing things
 - Skill mix
 - Centralisation v Local

Comments:

Change bullet point to Centralization WITH Local not versus

Sustainability

Challenge of working differently

Managing equity

4.2 Exercise Two: Validity of Working Assumptions

Attendees were asked to consider if each of the statements listed below relating to SACT are valid assumptions. The consensus of opinion at the 7 tables is numbered in the corresponding columns.

No.	Statement	Strongly agree	Agree	Disagree	Comment
1	Radiotherapy will be delivered in Altnagelvin and Oncologists will be resident there	2	5		<ul style="list-style-type: none"> • Some specialist XRT to remain in Belfast • Much discussion if oncologist could be resident • Query regional contracts • Population, funding issues, new treatment evidence, impact on decision re XRT service there. ROI • Concerns about recruitment and retention. Better to spend more time in units and have a centre based practice also
2	There will be continued growth in chemotherapy demand and capacity issues will need to be addressed	6	1		<ul style="list-style-type: none"> • Use the word "Systemic" as opposed to cytotoxic • Oral drugs • New therapies may be more targeted and complex
3	There are opportunities to explore chemotherapy being delivered in other locations	5	2		<ul style="list-style-type: none"> • Already happening but must be planned and equitable and carefully worked through • Needs linked to acute services • Near patient can be at cancer centre or home • There are opportunities to develop level 1 • Needs comprehension • Risk assessment
4	Near Patient Chemotherapy needs to be considered	5	2		<ul style="list-style-type: none"> • Robust back up plans required • Needs to have risk stratification • If linked to acute services • eg models for teams going to HCs, HCAH, mobile units doing it only where critical mass (Downe and Causeway) • For some patients some of the time • Need clear definition for 'near' • Management of chemo complications • Impact of near patient chemo, supportive services, how are they near patient, eg counselor • Must be cost effective
5	Although home chemotherapy falls within the spectrum of Near Patient Chemotherapy its widespread use is not envisaged	4	2	1	<ul style="list-style-type: none"> • Define widespread – consider further • Funding issues and not for all. May suit individual need • Would not be cost effective • Information and support needs re oral chemo • Staffing issues

6	We need to change the skill mix of staff	6	1		<ul style="list-style-type: none"> • Assuming there will be increased nurse and pharmacy roles • Terminology of skill mix can be confusing – suggest multidisciplinary and role development • Needs reworded to reflect review of roles & functions, skills and knowledge, extended roles • Roles & function of staff should be based around a care pathway reflecting expanding roles of team • Need to look at how roles change
7	We need to implement service improvement initiatives	7			<ul style="list-style-type: none"> • Regional coordination to avoid inequity in service • Depends what they are. Need to be able to do what is right for patient and have flexibility • Need baseline assessment beforehand. • Identify time, resource and assess effects of change
8	Acute Oncology Services needs factored into any future model	8			<ul style="list-style-type: none"> • Service needs to develop to allow this to happen • Non negotiable • Network view of medical staffing
9	All guidance points to the need for resident oncologists in Level 2 facilities providing Acute Oncology Services	1	3	2	<ul style="list-style-type: none"> • Clarify “resident “ , change resident to ‘dedicated’ • Agree need for AOS but not resident, don’t replicate current model • Resident or 5 day per week, ? on call, be telephoned to deal with queries OOHs • Need 7 day a week presence • Must be phased and work towards it eg 9-5 M-F to start • Not an on call service, there between 9 – 5 • Diversify from Belfast
10	Some change will have to be done in a cost neutral way. Any additional investment must be able to demonstrate increased quality and effectiveness	5	2		<ul style="list-style-type: none"> • Emphasize “some “ • There is inefficiency in the system
Additional assumptions that need to be taken into account: <ul style="list-style-type: none"> • Audit and evaluation • Demonstrate clinical quality and effectiveness and also patient experience needs to be measured • Assuming supporting services will be considered and reconfigured • Embrace IT solutions • Leadership • Pending review of AE services • Urology review may impact 					

4.3 Exercise Three: Preferred Option

Attendees were asked to consider the potential options for the future configuration of NI Chemotherapy Services. To facilitate discussion the JCCO levels of oncology service were used. It was acknowledged that these were restrictive in their application but provided a means of drawing some distinction between types of services. They were being used to help de-personalize the debate.

There was broad agreement that Level 1 type services would be worth implementing.

The elements of service that could potentially be provided in such facilities include:

- Safe dispensing and administration of certain drugs
- Patient assessment / Pre-assess / Assessment following decision to treat by Onc
- Risk assessment
- Patient education and consent
- Administration of chemotherapy / Simple chemotherapy delivery / Certain infusions
- Distribution of oral chemotherapy / Follow up and monitoring of oral chemo
- Supportive therapies e.g. zoledronic acid transfusion
- Supportive care (patient education and holistic assessment)
- Nurse/pharmacy led service
- There are different services provided in different ways across NI e.g. rapid response in N.Down will carry out blood transfusion, same service not available in E. Belfast
- Likely to be low volume but still needs to be cost effective

Potential environments for such services include:

- DGHs
- Community Hospitals
- Health Centres / Healthy Living Centres / New Health and Well Being Centres
- Local hospitals
- Nursing homes
- Mobile chemo units and patients home (may be a viability issue based on other supportive services available and numbers of patients. Local HSC premises may be close enough for most patients)
- Causeway Downpatrick Erne Newry = 1st goal / Wellbeing centers = 2nd goal
- Using existing health care facilities with patient choice
- Health care facilities with certain services available eg medical staff who could help with acute reactions etc
- Hard to reach areas, those geographically challenged
- Somewhere that treatment is available for anaphylaxis

What systems and processes need to be in place to ensure patient safety?

- Robust governance arrangements
- All level ones should be responsible to level 2 or level 3
- Appropriate, clearly defined guidelines - what is done where / Clear protocols e.g. toxicity
- Standards
- Risk stratification
- Monitoring
- Recording
- Chain of custody for chemo
- Incident reporting
- Emergency referral and access Doctor available to cope with anaphylaxis etc
- Immediate transfer if required / emergency back up
- Need NIAS on board so that urgent transfers can be facilitated so that patients not sent to inappropriate facilities
- Chemo delivered in one place, but chemo complications treated in another hospital
- Pre-assessment criteria
- Initial assessment and decision to treat / assessment of suitable patient
- Workforce issues and having the expertise available
- Education and training / chemotherapy trained staff i.e. not the district nurse
- Need to identify the different components of chemotherapy service e.g. assessment /decision to treat, treatment delivery, follow up, management of complications

How will a radiotherapy service at Altnagelvin impact on regional chemo services?

- Depends on what diseases it is going to treat in terms of radiotherapy / which bits of regional service will move to Altnagelvin / final business case for Altnagelvin
- Will Antrim patients receiving XRT in Altnagelvin receive chemo in Antrim or Altnagelvin?
- Some chemo treatment currently being given in Centre could be given in Altnagelvin
- Patients may attend Belfast Cancer Centre for surgery or decision to treat but get their chemo delivered in Altnagelvin
- Should be delivering a proportion of chemo – i.e. straight forward stuff
- May be a requirement to reconfigure the patient geographical flows
- Relies on communication between Altnagelvin and Belfast
- Clinical oncologist - deliver XRT and chemo
- Implications on workforce - recruitment and retention of staff, resident Oncologists
- Need Altnagelvin to be successful / sustainable so that staff want to go there and stay
- No clear patient pathways yet
- Staffing across Alt and Belfast will need to be assessed based on changed patient pathways
- Altnagelvin is a franchise of the Cancer Centre
- May result in reconfiguration of chemo services
- Should enhance patient choice

- Marrying patient choice and strategic direction can be difficult
- Could be difficulties ensuring consistent quality if 2 Centres start to develop
- Should try to keep all services together e.g. surgery chemo and XRT
- Patient caught between Belfast and Alt could end up traveling more
- Patients could get lost between sites if three different Trust provide care
- Need agreed treatment guidelines that Centres must adhere to
- Will impact on Craigavon and Antrim but residents of Fermanagh are closer to Craigavon than Altnagelvin
- May relieve existing issues with capacity
- Capacity would increase due to reduced traveling
- Improves access and capacity
- Full level 3 should be provided in Alt to ensure full utilization of additional resources
- Will impact on level 2 facilities going forward
- Will impact more on non regional bits – which is the bulk of the work
- N & W of Northern Board and NW of Southern Trust will now be going to Altnagelvin. Big knock on SHSC & Antrim & Causeway. Where will Alt Oncologists have to go for MDTs e.g. Antrim? (20 miles from Belfast)
- Three different MDT for one patient Concerns about impact of Alt. Unit and perception may strip services in Antrim.
- Number of beds needed in Altnagelvin for concurrent chemo radiotherapy. Will not be that many.
- 10% of XRT will still have to be given in Cancer Centre
- Downgrading on oncology service impacts on surgical service. It is a complex impact

How many level 2 services are feasible in Northern Ireland?

- Four – that's where haematology is and as the larger DGHs need to remain 4 level 2 services otherwise haematology would also need to reconfigure. Then see if there is sufficient work, need, money to develop level 1 service. This will probably be done by geography. Invest according to your current strengths.
- Four - The current four units (If definition day time oncology service and telephone ooh. Could provide on call service from Belfast to Antrim & UHD and a team approach to MDT)
- Four - The current level 2 would be OK and work if we:
 - improved allocation of Oncologists
 - change skill mix to stop Oncologists doing things that others can e.g. prescribing chemo by pharmacists
 - streamline lists, well patients seen first at chemo clinics, lists start on time
 - Oncologists arrive on time for sessions
- Four - Dependent on number of oncologists. Need to base on population densities. Would require an additional 8 WTE to provide AOS in each cancer unit. Is this feasible?
- Three
- Location of A&E departments would impact

Potential Options for Discussion

Option	Level 3	Level 2	Level 1
A	1	4	No (Current Model)
B	1	3 + 1*	No/Yes
C	1	2 + 1*	No/Yes
D	1	1 + 1*	Yes how many?
E	1	0+ 1*	Yes how many?
F	Other	Other	Other
* Enhanced Level 2 Facility			

Each table was asked to consider the above potential options and choose a preferred option. These are listed in the table below.

Preferred Option

Table Number	Preferred Option
1	C - with Level 1s
2	C
3	B - with x1 Level 1 at Erne with Oncology Presence
4	F - x1 Level 3 & x4 Level 2 with resident AOS at existing acute hospital delivery Model needs phasing in first instance. In short term need an on call Oncologist rota
5	B & C B linked in with A&E / new models of follow up With level 1 facilitates at Erne, Omagh, Downe, Newry
6	B
7	B (1 + 1* + redefined L2)

General comments on options:

- AOSs need to be provided in hospitals with A&Es
- Introduce level ones and recognize oncologist work needs investment in workforce to deliver a model similar to Cheshire
- To deliver acute oncology services (governance issue) need more Oncologists
- Consider roads and infrastructure therefore reconfigure ambulance services
- The current set up would work well if we improved how we used them. Once we have made the most of current facilities, then look elsewhere
- Haematology provision of service links to acute hospital laboratories to be factored into the decision making
- Political implications
- Most likely to support AOS and provide geographical cover as a transition to more diverse services
- Uncertainty re remodeling at Altnagelvin and what it will be
- Organizing a NI wide service within existing Trust boundaries is very difficult
- Need to ensure cancer centre and unit services are consolidated before level ones are developed. We need to know the service configuration and then look at any outstanding requirements and how they could be fulfilled. Can already identify suitable sites. Need to look at resources required and will these come from level 2 sites?
- Consultants spending more time in the units would make a very significant improvement
- Agree in principle with level 1 but need to address levels 2 and 3 first. However, could be easy to move a lot of supportive therapies from cancer centre and units which would be really helpful. This will require good information pathways and IT systems.
- Liverpool model – agree with Prof Clark- the levels are preventing us from making a decision based on patient centred care pathway. A&E and General Medicine to deliver the AOS. 9-5 service of resident Oncologists not 24/7. Access for A&E & General Medicine to advice during OOHs. Care pathway based on future models

What are the perceived benefits of your chosen option?

Option B	Advantages	Disadvantages
Patients	<ul style="list-style-type: none"> • Some Erne patients won't have to travel (if level 1) • Better care for patients from medical staff if they are readmitted to L2 Unit • Expertise on site • Level 1 make more services closer to patient particularly in WHSCT • On site with A&E better for patients • Patients benefit from expertise – same team • Patient Notes available • Support services on site • Chemo closer to home more convenient for patients 	<ul style="list-style-type: none"> • Some will still have to travel large distances • Added complexity
Profess	<ul style="list-style-type: none"> • More focus within roles to do only the things others cannot do /Only have to do roles that others could do for them • Economics of scale with Haematology Units and chemo provision • Own cohort of patients coming to same place • Skill base • Treating teams want to look after the complications they cause • Haematologists are also there • Expansion of roles • Range of professionals • Better working relationships between all teams – surgeons, A&E Consultants – all involved in AOS 	<ul style="list-style-type: none"> • Oncologists will have to change work patterns in relation to Units i.e. presence each day • Covering more sites – level 1 • Reconfiguration of jobs • Reluctance to change • Logistics of drug delivery • Resistance to change
Comm	<ul style="list-style-type: none"> • Relatively cost neutral • Integrated Network wide approach • Resident Oncologists more likely to develop services further • A greater sense of ownership e.g. development of nurse led clinics etc. • Changes could lead to reduced morbidity and mortality due to safer systems in place 	<ul style="list-style-type: none"> • Added complexity • Unpopular decision to be made and the fall out resulting
Option C	Advantages	Disadvantages
Patients	<ul style="list-style-type: none"> • Allows expansion of near patient treatment • Introduces choice for patients 	<ul style="list-style-type: none"> • Some will feel disenfranchised • May feel a lesser degree of service

	<ul style="list-style-type: none"> • Reduces patient waiting times and increases capacity • On site with A&E better for patients • Patients benefit from expertise – same team • Patient Notes available • Support services on site • Chemo closer to home more convenient for patients 	<ul style="list-style-type: none"> • Some patients may have to travel further • Added complexity
Profess	<ul style="list-style-type: none"> • Development, skill mix, specialism • Less traveling time for clinicians • Increases job satisfaction • Own cohort of patients coming to same place • Skill base • Treating teams want to look after the complications they cause • Haematologists are also there 	<ul style="list-style-type: none"> • Restructuring of MDTs required to sort new model • Negative impact on whole profile of a hospital service e.g. surgery etc. • May remove choice • Must have robust support and governance to avoid vulnerability/access to information • Covering more sites – level 1 • Reconfiguration of jobs • Reluctance to change • Logistics of drug delivery
Comm	<ul style="list-style-type: none"> • May not be cost neutral but may need pump primed and will deal with the increasing demand on services. May need to invest to save • Integrated Network wide approach 	<ul style="list-style-type: none"> • Initial costs • Political fall out • Added complexity • Unpopular decision to be made and the fall out resulting
Option F	Advantages	Disadvantages
Patients	<ul style="list-style-type: none"> • Improved communication re patients • Locally delivered service beneficial to patients with local accountability • Less inequity of service for patients • Enhanced quality could come out of it for patients 	<ul style="list-style-type: none"> • Patients may still prefer home treatment model
Profess	<ul style="list-style-type: none"> • May give better working environment • Better relationship building e.g. A&E, GPs etc, • Improved quality of the service the professionals can deliver 	<ul style="list-style-type: none"> • May feel some dislocation • Feeling ‘second class’ – but should not happen
Comm	<ul style="list-style-type: none"> • Education, audit and governance should still come from one place • Safety and sustainability (of the whole hospital)May save money 	<ul style="list-style-type: none"> • It’s harder to do this and move money around in this financial era

4.4 Notes from Panel Discussion

- The panel agreed that there are a range of possible solutions and the will to change is evident
- The current way is not sustainable
- The day was very much about shaping services around the needs of patient, delivering high quality care close to the patient, giving a clear view to the future structure of services
- There are indications that some of this can be done in a cost neutral way. Where is the potential to save within AOSs and chemotherapy Services? There is benefit in reducing inpatient stay and the number of investigations. Looking at impact appraisal done in England – Prof Clark stated that he made a sales bid for £100,000 per Trust = £700,000
- Prof Clark stated we seem to have level 3 sorted. He suggested it does not matter how many level one services there are, it is what level two services do that matters – sort that out first, do homework, and agree what patient mix should be.
- Role of Altnagelvin? It was the opinion of a panel member that it will not be functioning as a comprehensive Cancer Centre as it will not be delivering complex chemotherapy
- The term “Resident oncologists” is a misleading one. What is critical is that they provide a 9-5 service and are integrated into local governance arrangements, contributing to local policies, service improvements, education etc
- Reconfiguration of A&Es will have a huge impact on how to deliver AOSs.
- There are things we could be doing now, for example improving patient information, developing clear pathways and appropriate protocols
- How many oncologists are there in England by comparison with NI? Prof Clark stated that Yorkshire has 33% more Oncologists than the rest of the UK. They have 36 Oncologists for a population of 2.3 million which is still low in relation to patient numbers, treatment complexity and types of patients. The number of Consultants in NI appears to be way below recommendations. NI needs to develop Consultant nurse roles, nurse and pharmacy prescribing.
- We are not being preserved from public cuts we need to make the best of what we have got.
- There are other ways of prescribing – 99% of day case chemo in Merseyside is prescribed weeks before
- A panel member stated that we spend lots on all drugs in NI, multimillion pounds. £500,000 in 1995 - £19.3 million in 2010. The current increase is not sustainable; there is a need to be much smarter. Would clinicians be prepared to look at how we spend on current drug budget? Drug spend could be shifted to staff. NI is spending less than England. Top 18 drugs are patent.
- Drug spend is high because we have no proper CMGs – end result is that it is sometimes easier to prescribe next line of treatment than have a difficult conversation. Sometimes risk to patient for unknown benefit. CMGs will produce governance.

5.0 HEADLINE MESSAGES

- 5.1 The current service needs to change in terms of safety and sustainability
- 5.2 Services need to be shaped round the needs of patients
- 5.3 Agreement that level 1 facilities are worthwhile
 - Some suggestions to start small (in rural location) and learn from same
- 5.4 The major focus for service improvement should be level 2 facilities as it is these that matter. We should build on current level 2 facilities in terms of :
 - developing Acute Oncology Services (AOS)
 - having oncology presence 9-5 Mon-Fri
- 5.5 The most important driver for sorting out level 2 services is the need for AOSs.
 - Effective AOS will reduce length of stay and the number of investigations – this would off-set oncology resources
- 5.6 We need to begin to conceptualize chemotherapy services differently as there are four components which could each be done differently.
 - Decision to treat (dependent on MDT)
 - Delivery of treatment (skilled nursing and pharmacy)
 - Follow up (potential for change)
 - Management of chemotherapy complications (needs AOS)
- 5.7 There are other ways of doing things – e.g. prescribing, Merseyside chemo is prescribed weeks before and prepared and ready for patients in advance
- 5.8 We need proper CMGs/protocols to ensure audit of practice to reduce variation and justify spend
- 5.9 Haematology services are at 4 units – any changes to oncology will impact on them
- 5.10 In terms of the preferred options – it came down to two:
 - Retain 4 level 2 services and build them up, plus have level 1 (challenge is oncology presence in terms of PA and funding for same – could be off set with different prescribing??)
 - Reduce level 2 services by one and redistribute Oncologists

6.0 NEXT STEPS

A typed up summary of the workshop will be produced and distributed to workshop participants. It will also be used to inform the Chemotherapy Service Review, in particular the work of the New Models of Chemotherapy Services working group. The group will use the information gleaned to assist them in the production of a draft options paper, to go to the Review Steering Group for approval. The final version will be submitted to the NICaN Board by December 2010.

7.0 EVALUATION

What worked well?

- Group work
- Excellent discussion
- Professionals from different backgrounds
- Workshop facilitation worked very well
- Dynamic conversation
- Good ideas around change
- Prof Clark's presentation
- The day was all very positive
- Focused questions

What could be better?

- Too rushed
- Would have liked more time for discussion
- Would have liked another external speaker
- More clarity – point made re decisions being made on assumption of saving money rather than best practice

Comments

- It would be good to have feedback from the whole workshop

APPENDIX 1: List of Delegates

Name	Job Title	Organisation
Sharon Barr	Assistant Service Manager, Specialist Nursing	Belfast HSC Trust
Willie Barron	Assistant Director of Cancer and Clinical Support Services	South Eastern HSC Trust
Fiona Beattie	Assistant Director of Acute Services	Western HSC Trust
Louise Bowden	Team Leader	Belfast HSC Trust
Dr Tracey Boyce	Director of Pharmacy & Medicines Management	Southern HSC Trust
Ruth Boyd	Cancer Research UK Senior Nurse	Belfast HSC Trust
Wilma Boyd-Carson	Clinical Manager	South Eastern HSC Trust
Annette Burrows	Haematology, Ward Sister	Southern HSC Trust
Sally Campalani	Senior Nurse Cancer Services	Belfast HSC Trust
Una Cardin	Chemotherapy Unit Manager	Western HSC Trust
Dr Peter Clark	Consultant Medical Oncologist	Clatterbridge Centre for Oncology
Jackie Clarke	Consultant Clinical Oncologist	Belfast HSC Trust
Mr John Compton	Chief Executive	HSCB
Fidelma Connor	Oncology Liaison Nurse	Belfast HSC Trust
Dr Diane Corrigan	Consultant	Public Health Agency
Pearl Coulter	Haematology/Oncology Pharmacist	Belfast HSC Trust
Graeme Crawford	Macmillan GP Facilitator and NICaN Primary Care Group	Macmillan
Eileen Deery	Lead Nurse Cancer Services	Northern HSC Trust
Karen Devenney	Senior Manager - Patient Flow & IM&T	Belfast HSC Trust
Richard Dixon	Manager	Patient & Client Council
Hazel Eagleson	Manager	Belfast HSC Trust
Dr Martin Eatock	Consultant Medical Oncologist	Cancer Centre
Elizabeth England	Cancer General Manager/Lead Cancer Nurse	Western HSC Trust
David Galloway	Director of Secondary Care	DHSSPSNI
Fionnuala Green	Regional Lead Cancer Services Pharmacist	Belfast HSC Trust
Louise Gribben	Haematology Nurse Specialist	Southern HSC Trust
Enda Hanna	Manager	Belfast HSC Trust
Jacqui Harney	Consultant Clinical Oncologist	Belfast HSC Trust
Dr Robert Harte	Consultant Clinical Oncologist	Cancer Centre
Liz Henderson	Network Nurse Director	NICaN
Geoff Hill	Co Director of Cancer & Specialist Medicine	Belfast HSC Trust
Dr Dermot Hughes	Network Medical Director	NICaN
Dr Don Hull	Consultant Haematologist	Southern HSC Trust
Dr Anne Kyle	Consultant Haematologist	Northern HSC Trust
Davinia Lee	Executive Support Assistant	Belfast HSC Trust & NICaN

Dr Heather Livingston	Senior Medical Officer	DHSSPS
June Macauley	Unit Manager	Northern HSC Trust
Jill Macintyre	Head of Pharmacy and Medicines Management	South Eastern HSC Trust
Tanya Maginn	Unit Manager	Southern HSC Trust
Charlie Martyn	Medical Director	South Eastern HSC Trust
Jonathan McAleese	Consultant Clinical Oncologist	Belfast HSC Trust
Pat McClelland	General Manager	Northern HSC Trust
Caitlin McCoy	Ward Manager	South Eastern HSC Trust
Neil McDaid	Human Resources Manager	Belfast HSC Trust
Maire McGrady	Regional Lead Cancer Services Pharmacist	Belfast HSC Trust
Ewan McGrattan	Principal Pharmacist	Northern HSC Trust
Dympna McParlan	Chemotherapy Service Development Manager	NICaN
Bernie Michaelides	Head of Intermediate Care/Acting Lead Nurse Spruce Villa	Western HSC Trust
Anne Mills	Nursing Officer	DHSSPS
Heather Monteverde	General Manager NI	Macmillan
Elaine Mullan	Administrative Assistant	NICaN
Mary Novak	Clinical Sister	Southern HSC Trust
Dr George O'Neill	Chair Belfast LCG	Belfast Local Commissioning Group
Dr Angus Patterson	Clinical Oncologist	Belfast HSC Trust
Alison Porter	Head of Cancer Services	Southern HSC Trust
Nicola Porter	GAIN Programme Manager	DHSSPS
Deirdre Quinn	Pharmaceutical Services Lead	Southern HSC Trust
Fiona Reddick	Oncology Nurse Specialist	Southern HSC Trust
Maurice Regan	Pharmacy Manager	Belfast HSC Trust
Dr Paula Scullin	Consultant Medical Oncologist	Belfast HSC Trust
Danny Sinclair	Regional Coordinator for Patient Information	NICaN
Gillian Traub	Cancer Treatment Service Manager	Belfast HSC Trust
Jennifer Welsh	Director of Cancer and Specialist Services	Belfast HSC Trust
Dr Richard Wilson	Consultant/Senior Lecturer in Oncology	Queens University Belfast
Dr Eddie O'Neill	Network Primary Care Director	NICaN
Seamus McGoran	Director of Hospital Services	South Eastern HSC Trust
Sinead O'Connell	Pharmacist	Western HSC Trust
Stephen Kirk	Consultant Surgeon	South Eastern HSC Trust
Ruth Hall	Research Nurse	Southern HSC Trust
David Stewart	Clinical Oncologist	Belfast HSC Trust
Michelle Bekmez	FPS Lead	HSCB