Ayrshire and Arran NHS Board

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Chemotherapy Service Review

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Recommendation

The Board is asked to consider the approach taken to date by the Chemotherapy Review Team to public and staff engagement regarding the future delivery of services in Ayrshire.

The Board is asked to support a period of engagement with patients, staff and public representatives to consider the proposed model of care; the emerging regional model of care will be taken into consideration in terms of how local services may align to this.

Summary

NHS Ayrshire & Arran has undertaken a review of its chemotherapy services in response to increasing service pressures. Following a period of stakeholder engagement, an option appraisal process was undertaken over the summer of 2015. In addition, a Transport Survey was carried out over 2016 to conclude the initial review.

It was intended that consultation on the outcome of the Option Appraisal would be conducted in early 2017; this was delayed due to the Scottish Election process. Over this period, the NHS Ayrshire & Arran Cancer Team has participated in and contributed to a Regional Working Group relating to chemotherapy delivery hosted by the West of Scotland Cancer Network (WoSCAN). As this regional work has progressed, it has become evident that some models of chemotherapy service delivery have been developed around the UK, shifting the clinical evidence base, which may offer advantages over those that we had previously been considering in NHS Ayrshire & Arran.

In view of the time which has elapsed since the option appraisal and now with the emerging regional model of care, the scope of the NHS A&A review has changed. This indicates we require to revisit our engagement process to ensure patients and public remain involved in the identification of a new proposal. The SHC have also indicated that in light of the emerging regional work and the emerging models they would require to revisit their view previously expressed to NHS Ayrshire and Arran.

Key Messages:

Our aim is to achieve:

- a safe, sustainable service for chemotherapy prescribing and delivery, in NHS Ayrshire & Arran;
- continuous improvement to safety, patient experience and clinical outcomes; and
- a resilient workforce that provides the skills and capacity needed to manage anticipated increases in demand.

Glossary of Terms

NHS A&A	NHS Ayrshire & Arran
CEL 4 (2010)	Chief Executive Letter – "Informing, Engaging and Consulting People in Developing Health and Community Care Services"
BWoSCC	Beatson West of Scotland Cancer Centre, based at Gartnavel Hospital, Glasgow
WoSCAN	West Of Scotland Cancer Network – comprising of NHS Greater Glasgow and Clyde, NHS Lanarkshire, NHS Forth Valley and NHS Ayrshire & Arran
UHC	University Hospital Crosshouse
UHA	University Hospital Ayr
NMP	Non-medical prescribing – skilled nursing or pharmacy practitioners who have undertaken further training to be able to prescribe medication
OA	Option Appraisal - an option appraisal allows a wide number of views to be considered in order to create as robust an assessment of options as possible
SHC	Scottish Health Council
SACT	Systemic Anti-Cancer Therapy - throughout this document "chemotherapy" is used to encompass biological therapies and cytotoxic chemotherapy

1. Background

In 2012 a review was carried out in NHS Ayrshire & Arran, with the intention of identifying the most appropriate, safe and sustainable model for the future provision of chemotherapy delivery. At that time there were around 8,500 patients living in Ayrshire and Arran with cancer and in excess of 2,000 new cancer diagnoses each year.

The primary driver for the review was concern regarding service resilience in the face of an anticipated 9% increase in demand for chemotherapy treatments per annum. The expected increased demand was based on rising incidence of cancer (1.4% per year), improving cancer survival rates, new cancer treatments, screening and earlier detection of cancer.

There are significant clinical governance, safety, workforce and financial considerations around chemotherapy delivery and as activity levels continue to rise, these risks increase . To address these risks, a considered approach was taken to seek a long term solution, while at the same time working within the current system to make improvements to processes and accommodation, where possible, to improve patient outcome and experience.

A number of measures were introduced in 2013 to address immediate risks, including installation of improved air quality to the isolation rooms on both sites. Patient flow through Outpatients and the Chemotherapy Units was reviewed and improved, and communication processes between staff involved in service provision at both UHC and UHA was enhanced.

In preparation for an option appraisal of the service and having taken advice from the Scottish Health Council and local Health Economics team, a comprehensive engagement with patients, staff and public was planned. A Person Centred Communication and Engagement Plan, and a Patient & Public Involvement Plan was drawn up and implemented between 2012 and September 2013.

A Patient and Public Reference group was established, and eleven meetings took place in 2013, with extensive discussion. Cancer treatment pathways were mapped out, and potential outcomes of any service review were considered. The advice of the group guided the wider engagement exercise and design of the questionnaire, entitled “Developing Our Chemotherapy Services Together” (Appendix 1).

The survey highlighted the issues that were most important to people - a full Qualitative Feedback Report is available on the NHS A&A public website. As advised by SHC the questionnaire asked open questions and did not specifically ask if patients favoured one or other of the two hospital sites. Following the survey, discussions began with the Patient Reference Group about potential operational solutions, including delivery of chemotherapy on a single site.

Extensive staff meetings took place at both UHA and UHC oncology units, with views sought from staff in all key clinical services associated with chemotherapy delivery. This included nursing staff, consultant haematologists and oncologists, laboratory and pharmacy services.

These discussions were wide ranging and included considering the option of delivering chemotherapy on a single site, and also explored the opportunities this would provide for staff training, development and support. Senior clinicians indicated support for a solution

that would maximise safety and deliver the service priorities identified by patients, including moving away from the status quo.

Staff engagement outcomes indicated that staff were increasingly recognising and advocating change to the chemotherapy operational arrangements, in order to ensure a safe and sustainable future service for patients and their families.

Chemotherapy is prepared in specialist facilities within the hospital pharmacy department and each chemotherapy prescription must be verified by trained clinical pharmacists.

Pharmacy engagement was therefore particularly important due to the safety, workforce, financial, demand and capacity, and capital planning implications facing the service, and the potential risks in maintaining the status quo. In order to support safe and sustainable services going forward, the preferred option for pharmacy was a single site option for preparation, and for high risk chemotherapy prescribing and verification.

Overall, the yearlong engagement process clarified priorities for the future service, and links with patients, staff and the wider public had been strengthened.

The Lead Cancer Team planned to continue work with the patient reference group and all stakeholders to develop a model of care which would deliver the service priorities. The focus would be on developing a single site model at one of the two main hospital sites, and an option appraisal was undertaken to determine the final model.

2. Option Appraisal Process

An Option Appraisal was carried out as part of a review of chemotherapy services over summer 2015. The OA sought to determine the service model that would best ensure that the service remains sustainable in the long term and continues to meet the needs of Ayrshire and Arran patients living with cancer.

NHS Ayrshire & Arran provides chemotherapy treatments for the five major cancer groups (Breast, Colorectal, Lung, Urology and Haemato-oncology). Chemotherapy for the less common tumour groups (Gynaecological, Upper Gastro-Intestinal, Head & Neck, brain tumours, melanoma and sarcoma) is provided by NHS Greater Glasgow and Clyde at the Beatson Oncology Centre.

The scope of the OA did not include chemotherapy services provided in other health boards, including the BWoSCC, or other treatments including radiotherapy or surgery.

The OA followed the recognised steps as set out in guidance. The OA group membership included medical, nursing, pharmacy and management staff, with 25% lay representation as recommended by SHC.

Following due process a final short list was developed and the OA group considered four options:

- Status quo
- Enhanced status quo
- Centralisation (UHA)
- Centralisation (UHC)

Formal appraisal of the four options was undertaken. Each option was evaluated against the following seven criteria which were identified, defined and weighted by the OA group:

- Safe
- Effective
- Integrated
- Person-centred
- Sustainable
- Supports staff recruitment, retention and development
- Minimises disruption/impact to the service
- Accessible

All participants were provided with an evidence pack to inform their scoring decisions, and had the opportunity to question and clarify any issues around the options, criteria or evidence. They were then asked to score each option. Once scoring was complete the scores were used to calculate weighted benefit scores.

The Weighted Benefit Scores can be summarized as follows -

	Weighted benefit score
Option 1: Status Quo	503
Option 2: Enhanced Status Quo	591
Option 3: Centralisation (Ayr)	552
Option 4: Centralisation (Crosshouse)	617

Option Appraisal Summary

The aim of the 2015 Option Appraisal was to identify a preferred option for the safe and sustainable delivery of chemotherapy services in NHS Ayrshire & Arran. Options were formally appraised and centralisation of all chemotherapy prescribing activity and haematology inpatient beds at University Hospital Crosshouse was identified as the preferred option (Appendix 2).

3. WoSCAN Systemic Anti-Cancer Therapy Future Service Delivery Group

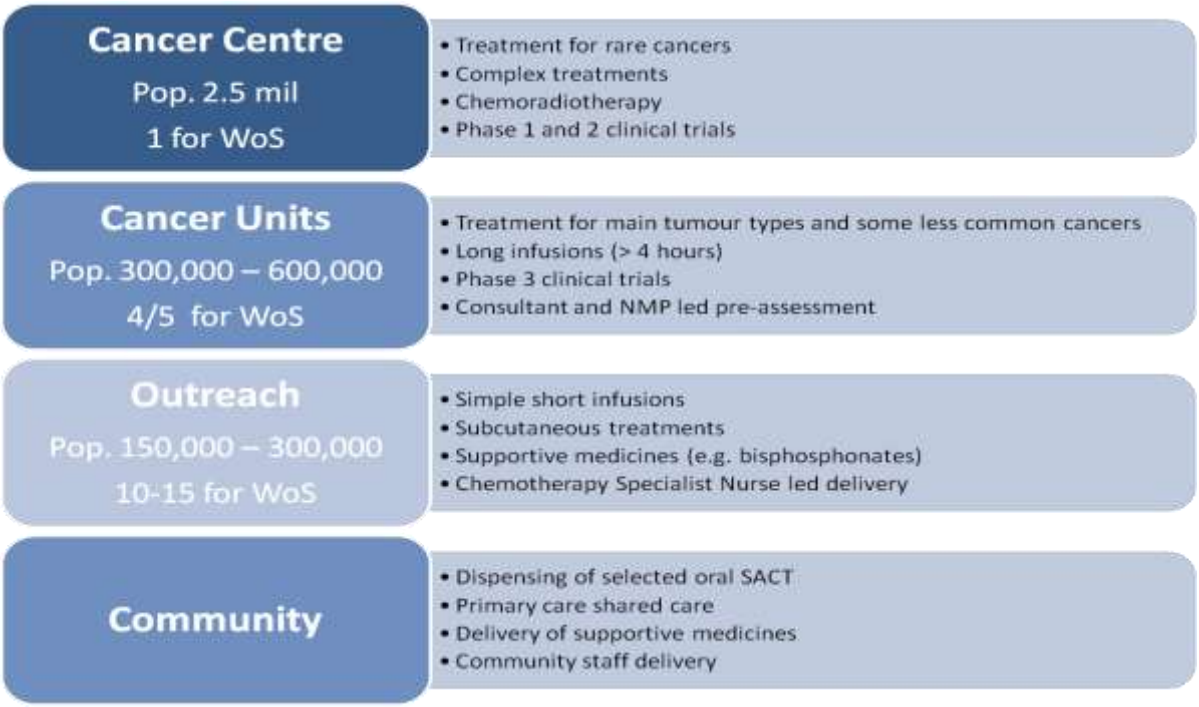
The SACT "Future Service Delivery Group" was established in August 2015 and its review looked at detailed capacity and demand modelling to plan sustainable future services for all health boards within WoSCAN.

Data demonstrated a 17% increase in total episodes of SACT delivered in the West of Scotland from 2013 to 2015, with reports of an increase in waiting times for patients to be assessed by oncologists to begin treatment in some Boards.

Evidence and clinical practice show that the mode of treatment delivery is changing with many new treatments given orally instead of, or in addition to, the intravenous route. This evolution in mode of administration impacts on the use of resources required for future treatment delivery, both in physical resources and configuration of the workforce.

A two phased approach to the project was agreed to identify the short, medium and long term improvements and developments required to meet future demands on services, and a report was published entitled Systemic Anti-Cancer Therapy Future Service Strategic Review and Emerging Future Service Model. This was finalised in November 2017.

The emerging regional model of care is set out below.



Whilst responsibility for progressing these improvements is the remit of individual Health Boards, there is merit in retaining a regional approach, adopting similar strategies while working in alignment with a regional model.

4. Pharmacy Aseptic Dispensing Service

Chemotherapy and other specialist medicines are prepared in highly controlled aseptic dispensing units in the hospitals pharmacy. Due to the risks associated with aseptic dispensing, the process is subject to increasingly rigorous regulatory and national standards.

Maintaining safe, sustainable and resilient pharmacy aseptic dispensing services is recognised as a challenge across NHS Scotland, and therefore following a recent national review a consolidated configuration of aseptic dispensing units was recommended, including one unit for NHS A&A at UHC.

Throughout the Chemotherapy service review there has been an acknowledgement of the importance of pharmacy aseptic dispensing in supporting safe chemotherapy delivery. While initially on site pharmacy aseptic dispensing of chemotherapy was preferred, the recommended two-step patient pathway for chemotherapy service delivery allows the increasing chemotherapy workload to be better planned and the medicines delivered “just in time” from a remote aseptic dispensing unit. This has been shown to reduce patient waiting times and improve the patient experience.

Therefore the local pharmacy aseptic dispensing service review has progressed in line with national recommendations independent of the local chemotherapy review.

5. Timeline since Option Appraisal Completion

Following the Option Appraisal final meeting in September 2015 the expectation of the team was to establish the public consultation process and to progress with this.

To determine the approach, the Team sought the advice of the SHC as to whether the change constituted Major Service Change. Our initial submission to SHC resulted in a request for additional information, including a more detailed Transport Impact Assessment. This was completed in 2016 (Appendix 3).

On the basis of the information shared with the SHC in September 2016 and on the option appraisal carried out in 2015 it was considered in October 2016 the proposal did not meet the threshold for Major Service Change and that a consultation to continue to inform proposals should be completed. NHS Ayrshire & Arran's Director of Acute Services and a Regional Performance Manager from the Scottish Government discussed the approach to consultation, which was expected to be in early 2017.

Given the timings around elections in May and June 2017, the consultation process required to be delayed until after the elections. The Board was therefore not formally requested to approve a period of consultation. The plan for consultation was intended to be developed post elections, over the past six months however the emerging model of care from the WoSCAN review has offered the possibility to enhance our proposed model.

6. Summary

In view of the time which has elapsed since the option appraisal and now with the emerging regional model of care the scope of the review has changed. This indicates we require to revisit our engagement process to ensure patients and public remain involved in the identification of a new proposal. The SHC have also indicated that in light of the emerging regional work and the emerging models they would require to revisit their view previously expressed to NHS Ayrshire & Arran.

7. Conclusion

The Board is asked to consider the approach taken so far by the Chemotherapy Review Team to engaging the public and staff regarding the delivery of the service in Ayrshire, and to support a period of engagement with patients and public to consider the proposed model of care; the emerging regional model of care will be taken into consideration in terms of how local services may align to this.

Monitoring Form

Policy/Strategy Implications	This Paper aligns to **People Strategy – People Matter** We require to have a highly engaged, empowered and enabled workforce, who can respond positively to changes and be willing and supported to work differently to provide sustainable services. **Code of Corporate Governance – Risk Management** We will strive to minimise the chance of adverse events related to chemotherapy delivery, assess and mitigate clinical risk and improve patient experience. We will undertake risk identification, prioritisation, treatment and monitoring, ensuring that risk management is an integral part of service delivery, and meet healthcare best practice where possible **Organisational Change** Underpinned by the principles of partnership; security of employment; redeployment and communication. Staff will suffer no detriment as a result of organisational change/service changes to their current terms and conditions, including income levels, which will be fully protected should staff be compelled to change job, responsibilities, location or hours of working. Contractual obligations will be met. **Staff Governance Standard** We will ensure our staff are well informed; appropriately trained and developed; involved in decisions; treated fairly and consistently, with dignity and respect; provided with a continuously improving and safe working environment.
Workforce Implications	Nursing and Pharmacy staff on both hospital sites will have the opportunity to undertake additional training and develop further skills such as clinical assessment and non-medical prescribing.
Financial Implications	The costs detailed in the 2015 Option Appraisal include both capital and revenue elements of necessary expenditure. Finance and Estates colleagues were involved in generating revenue costs; including staffing, rates, heating and cleaning costs and capital costs. Those costs associated with refurbishment, renovation or upgrade of ward areas were based on a projected lifetime of 40 years. All the costs generated are high-level cost estimates. All four options shortlisted in the OA would require capital investment in refurbishment and renovation. The refurbishment and renovation costs reflect the

	minimum level of investment to maintain the current level of service delivery. Full financial details included in the option appraisal document – based on 2015 costs.
Consultation (including Professional Committees)	**Developing our Chemotherapy Services Together 2013** – asked what was good about the current service, what would you like to see from a future service? This was repeated in 2015. **Ayrshire Cancer Forum** - voluntary services & support groups **Participation in Option Appraisal** - 48 individuals participated in the OA. These included - • Patient representatives - patients and representatives of support organisations • Clinicians • Nurses • Management representatives • Other staff - Scottish Ambulance Service, laboratories, pharmacy, allied health professionals and support staff. **Patient Reference Group** – 2013 and refreshed membership 2014 **Scottish Health Council** **Staff updates** - annual learning events and Clinical Nurse Specialist Meetings **Regional patient experience survey** - 2017
Risk Assessment	Current service and sustainability was risk assessed looking at the following – • Workforce – current and projected future need • Effective & efficient use of resources • Physical capacity of existing areas • Clinical Governance & patient safety
Best Value	**Governance & Accountability** – Current capacity will not sustain future demand based on projections for annual increase in chemotherapy. **Use of resources** – effective use of workforce (nursing, pharmacy and medical staff); effective and efficient processes; efficient use of pharmacy resource to eliminate or reduce high-cost drug waste; ensuring a resilient team and a robust service.

Compliance with Corporate Objectives	• Deliver transformational change • Attract, develop and retain a skilled, committed and adaptable workforce which is affordable and sustainable • Deliver better value through efficient and effective use of all resources
Single Outcome Agreement (SOA)	To ensure safety & sustainability of the chemotherapy service within Ayrshire & Arran
Impact Assessment Yes, Equality Impact Assessment was carried out – document attached  Equality Impact Assessment.pdf	

NHS Ayrshire & Arran

Developing our chemotherapy services together

Survey Report 2013

Full Qualitative Feedback

June 2013

Feedback received

What do you value most about cancer services?
Access to excellent care, delivered by the most appropriate person. Access to a medical specialist in the early stages where options being considered.
All areas explained and help if needed via specialist nurse.
Backup provided by cancer support.
Being able to contact someone if I have a problem and asking them about my concerns and usually getting advice on what to do or try etc. All this without waiting ages for an appointment.
Being able to ring the hospital with any health worries.
Being able to speak to people who understand the issues and care enough to listen and provide support.
Cancer Nurse Lorraine Anderson and her colleagues are there when you are at your most vulnerable, e.g. before surgery.
Care and attention given with a smile and humour.
CARING STAFF WHO HAVE AN EXCELLENT UNDERSTANDING OF CANCER PATHWAY
Continuity of care - seeing the same Consultant as this allows them and you to build a relationship and gain trust during a very difficult period. Towards the end of my treatment this seemed to have changed and you saw someone in turn. I did not feel this was acceptable
Everyone involved with my care in both A&A and GG&C was so caring, understanding and helpful and I appear to have made a full recovery.
General care attitudes of nurses and doctor. Made you feel you are an important person
Getting treatment that is helping me and letting me carry on with life as normally as possible.
Good communication - easy to contact
Having access to treatment required. The apparent genuine attempts to improve services and people's experiences.
Help is there if needed. Can phone and ask any questions whenever.
Helpfulness of all NHS staff. Availability of chemotherapy drugs.
I have been fortunate to have excellent caring services, I have great faith and confidence in my urologist (I always ask for him - and see him). Personal confidence helps - and staff support.
I value the proximity of where my treatment was given.
If you have a problem it is attended to immediately.
Information, not all given at time of enquiry.
It is local to me. One stop breast clinic. Wig supplier, Francis, Galston - excellent. Volunteer drivers for N.A.C.C excellent.
It works!! Good trained Specialists Good Facilities Reasonable accessible ++++++++++++
Kept up to date with everything that's happening with you.
Levels of treatment given and they keep trying.
No matter what time of day I know I can pick up a phone and talk to someone.
Nurses support. (Cancer Rehab Group).
Once again the hospitals and Doctors are so good, and so are the cancer surgeons
Only needed 5 chemotherapy sessions instead of 6 which was good.
Personal breast nurse NHS treatment Wig Staff are good at calming the patient and aren't afraid to have a laugh

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Professional and supportive nurses & consultants. Majority of staff seem to be well suited to the emotive work/ nature of dealing / living with a cancer diagnosis.
Receiving the treatment and feedback.
Staff are extremely friendly and always willing to do whatever they can to help you.
Seeing the Consultant re surgery to gain confidence. Seeing the Consultant to discuss, understand and plan treatment. SEEING THE SAME PERSON EVERY TIME - VERY IMPORTANT
Staff - their kindness, professionalism and approachability.
Staff at ward level are very compassionate and staff at x-ray are very professional. I appreciate that I am receiving part of treatment package locally during this difficult time
Staff spending time with me.
Staff taking the time to answer questions I have asked
Staff very helpful and knowledgeable. Explained treatment well that I could understand.
The attention paid to monitoring progress.
The care and attention every patient receives and personal counselling if required. Nothing is any bother. Thank you.
The care and attention of every little detail, scans, x-rays etc. The information given out by staff and the manner in which it's done. Cannot fault anything.
The care and attention of the Doctors and Nurses - nothing is too much trouble for them as they try their best to keep you at ease.
The care and feeling given by the cancer patients by the dedicated nurses. The very good work the volunteers do.
The care of the staff and treatments.
The caring staff team at Ayr Hospital
The confidence all the nurses and doctors give you going through cancer, really gives you the strength to go on.
The dedicated doctors and nurses.
The Doctor and clinic staff. I do not know where services there are.
The fact that I have a very good Oncology Doctor in Dr Featherstone. She is empathetic and always wants to do everything possible to help. Lynn is always at the end of the phone for any queries and to advise on different issues.
The fact that I have been able to be dealt with locally which I feel reduces the stress
The fact that they are there when I need them any time.
The fact that it is local to me so I don't have to travel far.
The help and support given during and after treatment.
The honesty and how caring everyone was.
The honesty, concern and friendliness shown by all staff.
The kindness shown by staff, especially breast care nurses
The positive approach taken by all involved in my treatment.
The professional care and attention is first class and just knowing that you can phone any time day or night for help or guidance is a great comfort.
The professionalism of the consultants, the focus on person centred care at Ayr Hospital. The time scale from diagnosis to start of treatment. ? The commitment of the consultants towards their patient.
The prompt service following diagnosis and the helpfulness and friendliness of all the staff involved in my diagnosis and treatment.
The speed at how quick you are seen by doctors.

The speed with which I was treated after diagnosis and the availability of the colorectal nurses on the phone during my treatment.
The staff and Doctors are very honest and helpful.
The time that all staff gave to patients, again the important listening. You are all treated as a person not a statistic.
The treatment I received and the care shown to me.
The way the nurses take time to see to me.
They are local and all the staff are extremely helpful and listen.
They are local. High level of professionalism throughout the care team. Good/easy access to a consultant.
They keep you informed at all times
This time around I haven't so far had to use/need all the other services but I do know/remember what is available.
To know that the staff are only a phone call away is very reassuring. It's great that it is a 24 hour service as well.
Using the car service to the Beatson made life for me and my husband more at ease coping with family commitments.
Very positive but not false hope. Good information.
Volunteer drivers and hospital staff.
You are kept informed of all your treatment and what to expect. It was also good to have a breast care nurse, knowing that you could phone if you had any problems or concerns. The breast care nurse also phoned at times to check how you were doing.
Friendly relaxed manner of staff
All nurses are very caring.
All the help available.
Sharing experience.
Group therapy.
The support and reassurance.
Getting results quickly.
How you are kept informed.
Nurses very mannerly.
They exist.
The support I have.
The support.
The Team
Life prolonging.
My Life.
Everything.
Everything.
Food excellent.
Being alive
Being treated.

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Please tell us how you think we could improve cancer services in Ayrshire and Arran?
A designated Cancer ward with only cancer patients would be a good improvement to the service. I think a lot of pressure is put on staff to find beds for cancer patients and too often they are boarded out to inappropriate wards.
A great service at the moment.
A key component of a cancer service is the treatment options that form part of the clinical trials service. Any developments in the cancer services need to factor in the needs of the clinical trials service to ensure that patients are not locally disadvantaged by not being able to participate in future studies due to service limitations such as space and staffing.
A self contained cancer chemotherapy unit on one site with appropriately trained medical and nursing staff on site.
As a district nurse, I feel the existing service is satisfactory, Station 15 provides a supportive service with any queries we have relating to clinical management, I would only suggest that we maintain robust communications relating to follow up care, chemo disconnect at home, for example.
As a whole I think we do well by our patients here within Ayrshire & Arran and those patients who attend Glasgow. However communication can be problematic. Removal of chemo pumps in community can be difficult at times due to chemo pump commencement times. I have had occasion to be called out to take a pump down at 21.30-21.45 at night when I have worked all day and been on-call that night. We have addressed this by carrying out training to maintain our staff's competencies for the 24 hour DN service. I know this process can be delayed due to unforeseen but removal times need to be taken into account. Think we need to have an appreciation for each other's roles and communicate more.
At home I could manage my symptoms myself and adjust my treatment accordingly. In the ward I was stuck to the ward routine and getting cover for nausea and heartburn was more difficult and there seemed to be a lack of flexibility.
At present after 15 years of treatment, everyday things seem to get better. Good work for all concerned. Most thankful.
Be able to have instant medicines rather than long wait. Often at hospital one and a half hours, 10 minutes to see Doctor then 1 hour to get medicines.
Better chairs in chemotherapy wards. Not very comfortable if you are on them all day.
By giving more information to patients and their families about the treatments they are receiving and what to expect during and after their treatments. By giving treatments closer to home.
Can understand why people may get upset as times vary.
Cancer is still a scary word and the focus is very much on treatment which I recognise it has to be, however wider support and understanding of the impact beyond the treatment and the life after should be addressed even if this is to external 3rd sector supports.
Cancer services could be improved by more information being given to patients re support groups, counselling services, etc.
Carers to be more informed/included during patient treatment.
Continue training programmes to inform all staff members of cancer services available.
Continuing to improve communications and shared pathways with primary and secondary care.
Day case area could be better organised in the North.
Deliver chemotherapy closer to patients' homes, e.g. community hospitals.
Delivery of care nearer or at home.

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Despite being a palliative care patient receiving chemotherapy, any time we had to go to hospital and the GP phoned ahead, we waited forever in A&E - quickest was 5 hours. In addition the chairs there are very uncomfortable for patients and we were told we couldn't have a big wheeled chair as I had brought the patient in by car to save on ambulances. In A&E the next step was the admissions ward. This was a complete and utter nightmare. When I asked politely once if the patient could have his drugs - heparin which must be given at a set time, and morphine which was 12 hourly and due for pain relief, I was told rudely, who was I and he would have to wait for a doctor to see him. I can understand the underlying reasons but what I did was give him the drugs myself. As it turned out, both times the patient was in there, the doctor woke the patient up to assess him, so he would have been in severe pain by then.
Direct access to specialist cancer care facilities when patients are admitted under emergency criteria.
Direct access to the cancer services when patient needs to be admitted rather than coming through acute medical receiving ward first. This step does not add value to the patients journey and exposes them to a high risk of infection
Direct admission to oncology from A&E rather than having to go through 3E. Training/education package, study day for all nurses to enhance knowledge to improve care of cancer patients. Referral pathways will be beneficial and useful when they come into place.
Don't change services; keep both sites as they are.
Each patient should have a meeting to discuss what is available appropriate for their needs, I have no idea what is available.
Ensure all staff explain who they are and what their role is to patients and families so they have a thorough understanding of who they are talking to.
Ensure people know why there are delays.
Expand provision to enable growing number of patients to receive support.
Fast track oncology patients from A&E to cancer wards and not via a medical receiving unit. Most patients expect to go straight to oncology ward.
Fast track patients to oncology Station 15 when requiring admission. Patients continually get upset by the fact they need to come via A&E and Station 7 when admission is required. They don't want to do this because no-one knows their history. Station 15 know these patients - 8 out of 10 times and never accept direct admissions.
For my mum, the care was excellent and local, however we have relatives and friends having to go to Crosshouse and even Glasgow for their treatments and this definitely seems to give them and their families extra stress that we did not have. I realise all radiotherapy has to be done at the Beatson, but in some cases, even just routine clinic appointments are now in Glasgow and this does not seem right.
Get a radiotherapy unit closer than Glasgow.
Have sometimes felt that staff can become a little defensive when questioned about decisions. At times students have been in consultations when consent was not asked for. Also sometimes staff can be slow to introduce themselves.
Having a special treatment area, i.e. not being treated in a ward with other non cancer patients.
I cannot think of any improvements, although I waited 17 days to see Ms Tovey - the Government guideline is 14 days.
I can't think of anything that could improve the services - but any improvement would be helpful in the future. As I get superb backup from 'cancer care', to bring me to and from hospital, to meeting the consultants and medical staff, who are totally professional.
I feel that there needs to be a nominated phone number/team to deal with chemotherapy issues. Neutropenia - with direct access to an appropriate ward to prevent such patients lying for prolonged periods in the emergency department - not the best environment for them.
I found the care and services excellent.

I think it is already an excellent service. The only problem has been the delay in prescription coming up from the pharmacy to the ward; however this could be because pharmacy is understaffed. So more staff would be the answer but probably outwith your control.
I think it is essential that cancer services are maintained at both sites at Ayr and Crosshouse. To centralise would not give the best services to the patients in Ayrshire.
I think it would help if you were given information in small doses during the course of your first treatment rather than "drowning" in information at the start.
I think that the chemotherapy services for my service function effectively given the geographical co-location of the oncology ward, the out-patient assessment area (The Ballochmyle Suite) and the proximity of relevant specialist nursing and urological medical staff as well as the service provided by the Pharmacy team on the Ayr site and laboratory services. The only way that this could be made perfect would be to have all the elements of the service in one area which would be difficult without a new build or significant reorganisation.
I think the management of patients during their treatment needs to be improved. Patients can be admitted to hospital at any time during their treatment and if the treatment is in a Glasgow hospital it can be difficult to obtain the correct information especially at the weekend with regards the management of this patient.
I think working towards delivering treatment locally helps as the travel home is not pleasant for the patient after the treatment.
If as you say the numbers are going up - is the staffing going up as well?
Improve access to the pre radiotherapy appointments at Ayr Hospital instead of having to go to the Beatson, i.e. hold more clinics locally. Review process for dealing with cancer patients admitted to A&E - don't make them sit in A&E waiting area, try to process them straight into oncology instead of hours in A&E and hours in receiving ward. Don't use oncology ward beds for non oncology patients. The ward and its specialist staff should be able to focus on oncology patients.
Improve education and training for staff working in A&E.
Improve education regarding cancer services within Ayrshire and Arran.
Improve the transport. Being away from home from 9:30am to 4:30pm when treatment takes 10 - 20 minutes is frustrating and reduces quality of life. Having to sit in a waiting room for hours until your appointment time to get treatment is stressful and cruel.
In my case I meet with my oncologist at Crosshouse and if my bloods are in order, I then have to trail to Ayr for my treatment. Surely all of this could be done at one hospital.
In my case nothing can be improved.
Increase availability of trained and experienced staff especially to cover when staff on leave or off sick. There is no resilience in the service.
Information not all given at time of enquiry. Improve information re treatment and outcomes. More information on side effects.
Information provided could be pitched more towards individual needs. Because people don't ask for information or immediately have questions doesn't necessarily mean they don't have concerns. More time required to elicit an individual's circumstances and potential difficulties could be beneficial.
It's an excellent service.
I've found that when I have had to use either NHS 24 or A&E services that the lack of quick access to my records, given that they are in the same hospital that I receive treatment at, has caused time delays. In some cases delayed treatment or in others it has resulted in inappropriate treatment. A better integrated system would save time, money and discomfort!!
Just do the job you are doing, that in itself will keep saving lives.
Fewer boarders in the units - close some beds if it helped.
Listen to yourself. This ward 3c/3a is exceptional.

Local Radiotherapy as travelling to the Beatson is very tiring and you have to rely on people to get you there.
Looking at why there is so much cancer and encouraging patients to look at their responsibility to keep well. Educate young women to truly nurture themselves at school.
Making sure staff are not working under duress with staff shortages.
More cancer care teaching services. Patients should go straight to cancer speciality wards instead of medical receiving wards.
More chairs in some areas when the clinics are busy.
More communication with community staff also shared care with Glasgow instead of only Glasgow dealing with patient who have had picc/hick lines that have blocked of or have run into difficulty
More education for staff.
More information and support for patients at home. More local treatment instead of long day trips to the Beatson. Patients with cancer treated in Oncology and not in General Surgery or Medical wards.
More information for patients/family regarding any benefits available (on diagnosis) and how to claim them. Information for patients/family about deterioration in condition - what can be expected.
More joined up approach where it is clear to the patient who is in overall charge of their care and if they will be responsible for co-ordinating their care. Someone the patient can contact as well should this be required both within and outwith standard working hours would be helpful to the patient. I know this happens sometimes but not all the time and I think this consistency would help to improve services further.
More Oncologists. More treatment chairs/ spaces.
More staff to administer chemotherapy and more available staff to cover when busy and other staff not there.
More support after the first chemo would be good as I know that personally I was terrified, and especially with living on my own.
More training required in CEPAS prescribing.
My father has skin cancer, he has received a good level of treatment but he has had to travel to Glasgow Royal.
My husband has to attend the Beatson every six weeks for review and to collect medication. This is in addition to having to attend there for all repeat scans - every 2 months. This is a long journey from North Ayrshire for someone who does not drive and therefore has to either rely on others or rely on public transport. Whilst accepting the specialist input of the Beatson, there must surely be ways of scans taking place more locally and the information being electronically sent?
My personal experience due to family members having cancer, is that the cancer services in Ayrshire & Arran are of a high standard.
Need even more joined up thinking.
Need more nursing staff -nurses are overworked and underpaid.
No suggestions, happy with service that my relative received
Of the 2 sites which provide chemotherapy services (and I have experience at both) there is a marked difference in the standard of nursing care; therefore I would suggest that this issue could be addressed and improved for the patient. I appreciate that this is a subjective view.
Only improvement would be to reduce waiting time in clinic.
Our experience so far has been what we would hope for.
Perhaps better travelling to Crosshouse from Millport.
Personal interviews at home would help.

Reduce clinic waiting times.
Retain the local personal service.
Review resources required to deliver the service if it stays on 2 sites.
Services require being local and administered in a patient friendly environment. The surroundings which are in place have improved but could be extended to accomplish the above in a more localised environment.
Sometimes I had to wait quite a while to receive my treatment as the room was so busy.
Sometimes the waiting time to start treatment can be very long.
Sometimes you have to wait too long for prescription for chemotherapy to come up to ward. This can add stress to some people.
Space out appointments at Chemotherapy ward so not so busy. Have more staff on to cope. It can be quite stressful sitting all day.
Straight access to oncology ward for neutropenic patients rather than coming through A&E which can be full of infection.
the travel to Glasgow for Radiotherapy is quite exhausting so Radiotherapy in Ayrshire would be a huge plus.
Unsure how to improve - perhaps criteria already in place could be further tailored for each individual. To improve experiences, service and time wasted in NHS setting.
Use only one hospital. There is no need to split the service. 2 locations are not needed.
When patients are admitted they should go directly to appropriate area, i.e. direct to 3A.
With expected increase in patients requiring to use the service in the future, a more robust method of forward planning re allocation of slots within the working week may help, being proactive rather than reactive. Also, during the rotation of staff into the unit, a longer period of rotation to encourage ownership may be of help to both patients and staff.
Work more closely with support groups, who can help during and after cancer treatment.
Would have liked more info prior to starting chemotherapy.
You would need more staff with experience, e.g. in attaching medication to port. No doubt the problem there would be lack of money to train more people.

What do you value most about chemotherapy services?
Advice and change of tablets re sickness.
Aftercare was very important to me and family.
Again continuity of care -
All the nurses they are very caring and considerate and make you feel at ease.
Availability no problem.
being able to deliver treatment at a local level the fact that there is no 'waiting list' as such for chemotherapy in my experience which I understand is happening in other health boards
Being alive.
Being kept informed of treatments and effects on my body.
Being offered this service and how lucky I feel about that.

Care and attention carried out with knowledge of what's happening.
Consideration and support from nursing staff, especially when feeling unwell and a bit down
Dedication of chemotherapy nurses. Drivers who volunteer to drive patients to and from treatment. The people who continue to try and improve the service.
Everything is explained as chemo is given.
Everything.
Expert treatment.
Get jags every morning have weekends off. Staff are waiting for me Staff at the other end of the phone.
Getting my chemotherapy at the scheduled time and not having to wait. 2 hour waits when stressed out about how you are going to feel later is unhelpful.
Good caring staff.
Good information - it's a key factor. Doctors being honest.
Good information on everything.
Having it local. Same Doctors who know us. Welcome by Specialist Nurse who keeps you up to date. Tablet version much better. Plenty of information.
Having the cancer treatment.
Highly professional Very good care and after care
How your mind is put at ease.
I had a bad reaction due to my immune system being very low.
I think is a great service. Just wish I could visit a nearer hospital.
I value the fact that we dispense oral chemotherapy patient's medication a matter of priority, trying to ensure that they get the best treatment and care available.
I was amazed at the number of patients attending the delivery of the chemotherapy services the staff were just lovely
I was fortunate in that my treatment was close to home and therefore travel was not an issue. I think distance could be an issue for other people.
Individual treatment suited to your personal needs.
It has helped me so much
It is available in Ayrshire and Arran and patients do not have to travel out of the area to receive this service. Consultants from Glasgow travel to see the patients within Ayrshire and Arran.
It was quick and efficient and gave me an opportunity to ask the staff any questions that I had. Cancer care was wonderful in driving me to and from the hospital.
Keeping me safe, making sure everything is double checked, looking after my veins. Seeing the same faces
Kept up to date with everything that's happening with you.
Knowledgeable staff.
Life prolonging and support services.
Local access for points for Consultant support is very good.
Local access to chemo unit local access to CNS

Local service with experienced nursing staff Input from cancer centre on the ground locally once a week and easy access to cancer centre for advice when needed
Local. Being able to have a relative with me. District Nurses excellent for Hickman line care and support.
Local, friendly efficient staff.
Nurse trying their best in very adverse circumstances on overcrowded wards.
Nurses are so nice.
Nurses ensured that I understood what was happening, put me at ease and answered questions. I value that they exist to do that. Help, support and advice are also given at the end of the phone if you need it.
obviously it is helping patients
On site administration.
Only had 2 treatments so far been very good.
Patients staying within their catchment area for treatment.
Pleasant and efficient staff who work well under pressure.
Prompt diagnosis and minimal time waiting for treatment.
Prompt few mistakes with ambulance time. Another time someone cancelled appointment without telling me or ambulance.
Provision of services local to patient/family/carer need to minimise unnecessary travel & facilitate visiting.
Proximity to home address
Service is streamlined. All team members work together for the benefit of the patient. Treatment is ordered, supplied and delivered safely and with a minimum of waiting time.
Simple, they keep you alive!! Within a week of diagnosis I had received first chemotherapy.
Specialist care.
Staff are so nice, I am not afraid to come in.
Staff were knowledgeable, attentive and careful so I always felt safe during my treatment.
Stopping it!
That I am able to get this service without being hospitalized and just have to attend for a few hours every 4 weeks.
That it was considered suitable and then made available to me when needed.
That it was local and very good. My mum was worried that she was a burden to her family (which she was not) but the fact that it was local, meant that she allowed us to help her and she didn't have to worry about 'us having to go out of our way just for her' .
That it's going to make me better.
That it's making me well.
That they're helping me.
That treatment works well.
The calmness of the nurses and the compassion and dignity shown to everyone.
The caring attitude of all the staff.

The caring staff.
The commitment of the staff at Station 15. To ensure the patient is foremost the patient / doctor/ nurse relationship
The fact that it finishes eventually and because of the attention you have been given you survive it and see other people in the same position as yourself.
The fact that my chemo can be delivered in a hospital close to home, in a comfortable and relaxing area.
The fact that the chemo actually shrinks the cancer/tumours.
The fact that the hospital is close to me.
The hope that it brings to beating cancer
The interest shown to all staff involved in my treatment.
The kindness and cheerfulness of the very hard working staff.
The nurses.
The nurses on the ward are very efficient and caring. They work extremely hard but always have time for you. They were also helpful in letting you know how to deal/cope with the side effects as were the doctors and nurses at the clinic.
The quickness I received getting my operation since I was diagnosed with cancer and the after treatment with the chemotherapy.
The relaxed atmosphere the kindness and care given all to make you feel "at ease" as far as possible.
The speed with which I was treated after diagnosis and the availability of the colorectal nurses on the phone during my treatment.
The staff are all trying to do their best and are all welcoming and friendly despite being very busy and pushed for beds almost every day. There is good communication between disciplines
The staff who do a very difficult job and, although I suggest more time with them prior to the session, I am aware of how very busy they are
The support.
The Team.
The way nurses take time to see me and treat me well.
The way the nurses who staff the chemo room carry out their/your treatment.
They are local, high levels of professionalism throughout the care team. Easy/good access to the consultant.
Time spent one to one.
To help me to get better and the staff were very efficient, got lots of information.
Understanding.
Willingness to try to treat the patient as an individual.
Working in Pharmacy I know we try our best to prioritise the oral prescriptions for chemotherapy patients so they do not have to wait too long.

Is there is anything we can do to improve chemotherapy services for patients?
A bit more individualised communication pre-treatment about what to expect. More information re resources

about dealing with range of side effects (in addition to written materials that may be provided).
A brief tour/ introduction to suite before actually came in for treatment as environment a little intimidating first time round.
A joined up booking service instead of chemo care, beatson system and PMS none of which talk to one another. The amount of confusion caused and extra man-hours spent trying to ensure that clinic appointments match up with treatment appointments is totally unnecessary. Often there are communication breakdowns which mean patients are being overbooked or not booked in at all. There must be a better way to manage it. Ideally ring fencing beds so that staff don't have extra stress of trying to find beds and patients don't have stress of thinking they are coming for treatment and then not getting it due to lack of beds
An area which is better for relaxing in when in hospital (similar to friends of Beatson suite at Glasgow).
Ayr Hospital treatment area is too small. Claustrophobic atmosphere, lack of privacy and confidentiality when discussing issues with doctors. As more people receive treatment, this will only get worse.
Better access to nurses and doctors that know about chemotherapy, more doctors and nurses.
Better communication between staff at clinics and pharmacy regarding when a patient is coming to pharmacy to collect oral meds so that we can be more organised in pharmacy to have meds ready. This would prevent the patient having to wait longer.
Better staffing - staff often pulled from ward that had less experience.
Capacity space in waiting facilities Access to benefits advisories physios dieticians etc while awaiting treatment ? Enhanced environment? Maggies Need to take on board comments from better together work which have never been moved forward
Chemotherapy requires intake and outgoing of body liquids - urination is counted (bottles). Perhaps a better system of count could be organised, if night shift fail to count one then the patient does not get out first thing in the morning, they have to wait until they have been seen by the doctor on the ward round.
Clinic at Ayr Hospital.
Consistent number and skill mix of staff in the chemotherapy units especially on the busiest days would help staff and patients with communication and seamless care. Backup for staff grade perhaps utilising CNS's
Could the humidity be improved in the ward?
Delivery of Herceptin at home, thus removing the need for continued contact with Station 15 and supporting the pt to move forward in their journey Station 15 day hospital chairs are not the comfiest when in them for 3 hrs plus. Lack of privacy to ask those specific questions, hence they may not always be asked - a very brief private consultation prior to each chemo session
Due to the high turnover of patients receiving treatment at the one time I felt at times the service was very impersonal and lacked privacy. To address this would mean having more staff and possibly a separate room where patients could be spoken to re concerns and problems they may have.
Ensure all members of the team delivering services work together to provide the best service.
Ensure good information at all times.
First thing in the morning lots of hold ups. Better organisation between Ayr and Crosshouse.
Get rid of the management as they do not listen. Was in for 3 hours too busy and no one listening to them.
Have proper times to get taken instead of waiting for a chair to become available.
Having been through this and looking back everything that could be done was done. Chemo is never going to be enjoyable but anything can be improved on.
I can't think of anything. My mum was very scared going for Chemotherapy, but the treatment she had at Ayr Hospital, and the kindness of staff there made this less of an ordeal for her, to the point that after the first couple of sessions she appeared quite relaxed.

I don't like needles lol. You have to wait a while for treatment to come up.
I had no problem with the services at Crosshouse apart from one issue which was dealt with quickly.
I have had no problems so can't comment on improvements.
I have no complaints about the service I have received.
I have not had a treatment at the time allotted - due to overcrowding on the ward and beds being allocated by " Bed Staff" so that the beds were in use by patients admitted overnight awaiting a doctors visit.
I meet with my oncologist at Crosshouse and if my bloods are in order, I then have to trail to Ayr for my treatment. Surely all of this could be done at one hospital.
I think the communication between the medical side to patients could be better, i.e. transforming patients of all areas of treatment.
I think the service I receive at Crosshouse could not be improved as it is first rate at the moment.
If possible reduce time between clinic and start of treatment.
Improve funding arrangements for appropriate new treatment regimes.
Improve information re treatment and outcomes.
In relation to Ayr Hospital I feel they have got things just right.
Increase the availability of staff trained to prepare, check and administer chemotherapy. Treatment delays experienced when day unit short of trained staff. Cannulation attempts by less able staff resulting in significant discomfort and stress. Increase the capacity in pharmacy as they often seem to struggle to keep up with demand.
It has become very hard to deliver the service on 2 sites as resources are then divided. Either the service has to be delivered on one site or the resources required to deliver the service are increased to ensure patient safety
It would have been helpful if the reactions to chemotherapy had been explained in more detail so we would know what was to be expected.
Less waiting time and more space, and air, in waiting area.
Listen to patients. Check that your protocols are up to date with the treatment given, so that unnecessary drugs are not given.
Ill patients receiving all day treatments as I did only have a sandwich and tea and biscuits. I was leaving home at 8.30am and getting home at 5.30pm - should be given a cooked meal.
Localise treatment rather than travel to Glasgow.
look at delivering treatment at different times - not 9-5 service however in order to achieve this would need a review of staffing levels in order to provide a more flexible service also capacity within the unit - space / beds etc - sometimes patients coming in for treatment need to wait hours to get a bed and start treatment which can add to stress and anxiety - both patients and staff
Making sure all nurses are equally experienced and good at cannulation. Make sure I get my chemo at my appointed time not two hours later - much more distressing.
Minimise side effects.
More access for tumour types rather than them travelling to Glasgow.
More info on side effects etc.
More private.
My father had chemotherapy in 2010 unfortunately he had to go to the Beatson for his treatment he was 85

and wood have benefitted from having the treatment delivered locally.
My own experiences were excellent.
Need more nurses to cover sickness. Extra pumps and drip stands would save waiting times.
Need to be patient can take time.
No comment.
No, everything was explained throughout treatment making it as pleasant an experience as possible.
No, except ambulance time.
No, we are very forward thinking about patients and communicate regularly to improve our service where necessary.
Prescriptions to be there quicker for patients waiting to get their chemotherapy.
Provide chairs that are comfortable. You have to sit for a while.
Reduce delays when waiting for drugs. Chairs were uncomfortable after time. Lack of air conditioning in Treatment Room.
Reduce waiting times at clinics, increase seating at clinics especially Monday pm XH lung clinic. Reduce waiting time at XH pharmacy.
Reduce waiting times at clinics.
Reduce waiting times for treatment.
Shortening time of medication from pharmacy to ward. Support patients to self care.
Shorter waiting times.
Sometimes the chemotherapy room is very busy and staff are worked extremely hard and appear to be overworked / understaffed. One slight worry is mistakes could be made.
Spend less time waiting in all departments.
Station 15 at Ayr Hospital appears to be at full capacity - would help if it was allocated additional staff, space and equipment. Conservatory waiting area often has extreme fluctuations and not enough seats/space especially for wheelchair access.
Tablet form.
The hanging around, it takes so long.
The only problem I have had and it has happened on a number of occasions is that there is a delay in my prescription coming up form pharmacy. This is also happening with the Herceptin treatment. I phone the day before to confirm I will in for treatment however this makes no difference. On one occasion I waited 3 hours before the Herceptin arrived.
The waiting around - the first day I had chemo, I was at the hospital for over 9 hours due to a delay in getting the medication to the ward.
The worst feature is hanging about but I realise the process takes time.
Treatment received in Beatson as was receiving radiotherapy at the same time. Transport was the negative issue as none was booked and it was stressful having to get transport. Improve the transport services.
Try to alleviate any fears a patient may have regarding their treatment.
Try to cut down waiting times in clinics and also the time taken for meds to come from pharmacy to oncology ward.
Try to improve waiting times for treatment to begin when in hospital for chemotherapy. Experienced hours of

delay after arrival at scheduled time before actual treatment commenced. This seems to have improved recently since computerisation introduced.
Trying to improve on waiting times for chemo etc to arrive from pharmacy. More treatment chairs! On occasions chemo was available but no treatment chair free!!
Venue checked before first chemo. Unnecessary delays could result in treatment, if not.
Waiting times in some of the clinics are quite long. The staff always tries their best but sometimes it gets hot and uncomfortable.
Waiting times.
Yes, stop the patient having to call to confirm the day before treatment. It usually was not suitable for me to make or receive that call.

Please use this space to make any other comments or suggestions about chemotherapy services.
All staff at Crosshouse from cleaners to doctors are first class. Obviously more staff would improve services but that costs.
A lot of staff sick. Heard staff talking about Bank Staff. All nurses / Medics are angry as nobody listens to them. Management priorities higher than patients.
As someone who has worked at Ayr and has recently had experience of a relative using XH, I can't stress how important it is to patients to maintain a local service that is easy to access.
Be more honest about side effects - your hair will fall out rather than your hair may fall out.
Because of the system in place you could be all day at the hospital Clinic in the morning refer to ward wait on drugs coming up from pharmacy - call take all day. But then again its only 1 day every other week so you can cope with it,
Both as an inpatient and a day patient I have found that although the standard of food is reasonable, it could be nutritionally improved by a wider choice of fruit and vegetables, multigrain and wholemeal bread options always available for sandwiches and healthier fillings. (Currently only cheese or processed ham!!)
Cannot up till now.
Can't as it has been perfection.
Cepas does not always benefit the patient causes long delays.
Cepas prescriptions are still unclear when we print them of causing quite a few issues in the department.
Clinic always very busy, always long wait to be seen i.e. appointment time 10am and not seen until 11:30 etc.
Does not seem to be much room in the chemotherapy room, could do with a bigger area.
Don't care where it is Ayr, Crosshouse or even Glasgow as long as I am looked after by experienced staff in whom I have confidence.
Good to be reassured as it is scary.
I feel it is extremely important whenever possible to see the same consultant. Building up a rapport and trust between the patient and Doctor is vital.
I had bloods taken at my local health centre the day before my oncology appointment which meant I did not have to wait about for blood results on the actual day, which was a benefit.
I loved the way staff tried to be flexible with my family commitments when my WCC was down. They did everything they could to support my family and myself.
Increase nursing staff numbers
More clinic space would be wonderful or time out spaces where we can speak privately to anxious patients or go over information discussed again. At present this can only happen in the corridor which is less than ideal
More information on side effects.
More personalised service sometimes felt like a cattle market. Again staffing issues should be addressed as staff under pressure and patients could sense this from them. In turn then doesn't promote a calm atmosphere.
More privacy would be helpful, especially for first treatment. Clearer access arrangements for patients to contact Cancer Nurse Specialists would be useful.

Personally I think the cancer wards are understaffed. I think the doctors and nurses have an extremely busy day and applaud them for remaining so positive and caring and for treating the patients as individuals.
Seems fine to me.
Services are very good - only improvement would be a reduction in waiting times as previously mentioned, also in 2A and particularly in waiting for prescriptions from pharmacy.
Shorter waiting times at the Tuesday morning clinic.
Some of bottlenecks with treatment seem to be due to pharmacy issues / capacity - is there scope to improve on this?
Sometimes clinic runs late, but this is due to nature of patients and time needed by those patients.
Staff in ward really good and consultant really good to. Complementary therapies service was excellent.
Staff really good although they may have told it again and again they always make you feel you are the first.
The old style chairs were much more comfortable The old style "Hot Packs" worked much better. These new ones don't heat to half the temperature of the old ones.
The only negative comment I would have is that the treatment area is perhaps not big enough for the amount of patients that need treatment. However, this did not seem to worry my mum very much.
The service I have received and still receiving has been first rate. How thankful I am for the Health Service.
There is very little that needs improved, just keep up the good work.
There sometimes was a delay with the chemotherapy coming to the ward from pharmacy which meant the treatment started later and finished later on one occasion we found ourselves still having treatment until about 8.30p.m.
They don't need to make any changes.
Treatment times need to be more closely adhered to and wards less overcrowded.
Try to streamline the service so that less time is spent waiting to see doctors, start chemotherapy, etc and as a consequence patients could spend less time in the hospital.
Unfortunately it doesn't help anxious patients when they come for treatment and find they have to wait for beds.
Use the chemotherapy sessions to review how I am and don't require me to attend another outpatient clinic for little purpose.
Wait for pharmacy prescription is dire when feeling drained already - it's a long walk for some people. Waiting area at morning clinic is hectic and there is not enough room to sit when it is very busy.
Waiting time between being assessed and receiving treatment is often long due to pharmacy delay. Treatment room and individual patient space is very small. Staff often struggle to find a room to have a private chat with patient/family.
Watch patients are not put on information overload, especially at the onset of treatment.
Whilst everyone's journey is individual to them at times services/ options did not always feel patient centred. Once professionals had made decisions about treatment there didn't seem to be much scope for patient to consider alternatives.
Would have liked more info prior to starting chemo.

Please use this space to make any other comments or suggestions.
Although I have outlined a few issues, overall I was comfortable with my treatment. Thank you.
A drop in service would be a big plus.
Can't fault the treatment overall.
Car parking to get to clinics can be a huge problem and at Ayr Hospital this can only get worse when Heathfield clinics are also at Ayr!
Carry on as you are doing.
Don't really see how you could speed up the time from clinic to treatment being given as drugs will be given depending on each patient condition. Just grateful to have been given the treatment I have received over the

past few months.
Enablement processes have been established as a first line approach to providing care. In order to integrate services there requires to be a more integrated approach with all services
Found I was very drowsy, found I was very up and down.
Found post operation to chemo to discharge very good. Transport / Location / Parking was an issue. Particularly for Public Transport users.
From working with patients few have bad things to say about the chemo service. I think they like that they are kept informed of any decisions and the reasons behind them, and I think this helps them feel that they are contributing/being involved and help to deal with the cancer.
Happy with service received.
Have been in Station 15, Ayr Hospital and all the staff have been very nice, professional and understanding. Social services have been exemplary in setting up homecare so that I could be home.
Have not yet started chemotherapy so can't comment.
Having a breast care nurse was just fantastic support - physically and emotionally. I honestly can't thank my entire team enough. Incredible service!!
Hints and tips about treatment would be good.
I am healthcare professional and would like to be treated as one! As in prognosis - further treatment - or alternative treatments.
I am now a year down the line and am doing great with the excellent help of Dr Featherstone, Dr Bose and Nurse Pamela Beattie. Hopefully this stands me in good stead for the future. Thank you.
I can only praise the staff who work in this area for the professionalism when dealing with patients and their families.
I feel there needs to be better channels of communication with regards the symptom management of patients undergoing chemotherapy.
I have been well looked after.
I have had reports from clients I have seen that their family member was given good service and support and they were happy with the service
I have only praise for ALL that work at Crosshouse Hospital in the cancer field.
I have only praise for all the staff and facilities that I have to use during my treatment.
I think service user feedback and experience on a regular basis could perhaps enable and inform service providers of any issues that need to be addressed. i.e. Regular reviews.
I think the staff in 3C are great.
I value the fact that I get my treatment at Crosshouse and don't have to travel to Glasgow for it.
I was diagnosed with a stage 3A breast lump at age 52 years 7 months. If I had a mammogram at age 50 the lump may have been detected earlier. Ironically 2 months later at age, almost 53, I was invited for breast screening - too late.
I would have travelled anywhere to get the necessary treatment but having listened to the group I think the majority of people would prefer their treatment locally. Sometimes those who are at "the top of the tree" forget they are dealing with people who have been given a diagnosis which has frightened them and they know very little about it. Questions are vital at a time like this no matter how silly they seem. Bedside manner leaves a lot to be desired at times. Further training required.
I would just like to say how grateful we should all be to have such wonderful Doctors and Nurses. They are the best

If a person is being diagnosed for the first time I think it is imperative that they have a friend/ family member there for support, and if this is not available a member of staff/ volunteer to attend to patient before being allowed to return home.
In the climate of recession and increased demands upon the NHS, creative ways of working are required throughout the Trust!
Keep the standard of the food up as this greatly lifts moral and these islands of normality help to pass the days.
Maybe this will help you to realise the money you pay for our cancer care to GG&C is well spent and the co-operation between the 2 Boards seems to work well except for getting blood results between RAH, IRH and Crosshouse. Perhaps it would be possible to be weighed, bloods taken and results done in our own surgery and made available before chemo day as I had to travel to Greenock several times to be turned away as my bloods were not good enough for treatment. This added considerably to my discomfort at the time. Thank you for everything that was done for me. I will be eternally grateful.
Member of staff take responsibility for planning and organising following days work load i.e. nurse led patients still being left on consultant review list
My consultant is Ms P. Whitford, the service that she delivers and the team behind her do a fantastic job. From mammogram to chemo starting was less than 3 weeks in total. Considering the volume of patients this was a great result for me. NHS staff do a great job in very difficult circumstances sometimes. Fantastic. Keep it up!
New advert for bowel cancer really good. Good team, including the ladies with the tea.
Often correspondence slow however new IT systems in future should allow community access via EMIS/clinical portal to patients documents more quickly
On the whole, my experience of treatment has been very good. Everyone on staff has been kind, cheerful and caring. I have also found the staff very supportive not only of patients but of each other.
Once started the services is very good.
Patient transport services should be evaluated - drivers use "rush hour" to dictate when they should be "away" rather than patient's needs. Where a patient is using patient transport services treatment rooms need to be more flexible. It's cruel, unnecessary and unacceptable making someone wait for 2 hours or more to get the treatment just because they are early due to the transport. It is also unacceptable for someone to be away from home for 7 hours a day for several weeks for a 10 - 20 minute treatment - more so when the treatment kicks in and they are very sick, tired and in severe pain.
people don't want to travel to far to receive their treatment, especially when they are not feeling well
Please- if patients are registered as palliative care can you give a bit of thought about what happens if they are admitted because of e.g. an infection or other symptoms. People don't just die quietly of their cancer. They have all sorts of other issues. Is it too much to enable them to have a bit of special treatment going through A&E and admissions. Please? This was nearly 2 years ago but it still lives with me and upsets me .And if it were someone without a relative with them I dread, absolutely dread, to think how they would manage.
Sometimes it seems that if you have a lung, breast, or prostate cancer you get more support. With other cancers, especially if you need to go to Glasgow for treatment, specialist nurse care is not so good.
Staff in general keep us as comfortable as possible. Waiting time for patients is an issue.
Support for young women to truly nurture themselves before cancer has a chance to develop, e.g. in schools (breast cancer). Support for women with breast cancer to nurture them (not pampering) but truly nurturing e.g. baths, self massage, lovely foods, and gentle walks. Empower the women with breast cancer with ways they can support themselves. Start with the next generation so that the statistics don't get to ' 1 in 2 '.
Take note of where people are travelling from when giving appointments, as the patient is often very tired during the course of the treatment and unnecessary journeys are exhausting.
Tell patients what will happen if chemotherapy makes them ill. Patients often attend not knowing why they

have certain symptoms or why they have to be admitted.
The staff that you have got are great, you just need more.
Think patients getting chemotherapy should be given more space while having the treatments.
This is a much more caring and relaxing experience that I had expected. I feel that I am not fighting this cancer alone, as all medical staff, make me feel part of a team, and are doing their utmost to help me in every way possible. So, thank you all very much for your professional care and attention.
Treatment using EPO to improve my haemoglobin levels very successfully is now no longer available on financial grounds. I now find that, during my current chemo treatment, my energy levels are such that I cannot maintain a good exercise level which I had been able to do in previous treatments, thanks to EPO. Given that exercise is an important part of maintaining a positive mental attitude and physical fitness it seems a very poor short term decision to make EPO unavailable. Long term benefits are obviously not considered when decisions are made about cancer patients. Is this because they are assumed to be about to die??
Ward could be tidier - boxes and equipment in the corridor. Frequently very difficult to drop cancer patient at Ayr Hospital front door. Empty ambulance transport, delivery vans and cars often parked in drop off area. At peak times there can be 6 empty ambulances blocking drop off area - be better drop off by ambulance at a dedicated area. Enforce non smoking areas outside Ayr Hospital - why do cancer patients have to walk through smoke from people standing at front door who ignore no smoking signs?

How would you describe your most recent experience of cancer services in NHS Ayrshire & Arran?
A first rate service from routine mammogram through operation, chemo radiotherapy and Herceptin. Again all the staff have time to care and listen.
After long stay in hospital all staff were very helpful in planning regular home visits with view to getting home permanently.
All of my experiences, no matter what it has been for, have been great.
All staff are excellent in their manner dealing with you.
As I said above, plus it's an excellent service.
Ayr hospital is great, friendly staff.
Breast service - Crosshouse excellent. I knew and had confidence in the team. Clear Consultant leadership
Cancer care of patients is dealt with at an extremely high level. Patient treatment is paramount. The voluntary services i.e. cancer care (transport) is an excellent organisation.
Care and respect given at Crosshouse was 1st class. Felt I was only a phone call way if feeling anxious.
Comprehensive and efficient ongoing treatment e.g. follow up scans scheduled at one clinic appointment carried out and results available for next clinic appointment.
Continued outpatient appointment friendly staff no delays
Doctors excellent. Clinic waiting times too long. / Treatments chaotic e.g. chemo - lost; medicine to take home - lost Treatment times altered, delayed. no one appointed as a point of contact to talk to no advice on diet care etc.,
Done in a most professional manner.
Dreadful. At my last clinic visit I had an 11am appointment but was not seen until 12.45. The clinic visit prior to that, I got 24 hours notice of my appointment and when I got there was scolded for not attending an appointment I did not know about at all.
Excellent
excellent
Excellent at Station 15 Ayr
Excellent - Today I received herceptin intravenously in ward 3C Crosshouse.
Excellent attention.
Excellent service all through treatment at all times.
Excellent!! The staff are wonderful and do their best to help.
Excellent.

Excellent.
Excellent. Everyone works as a team however has their own role. From diagnosis everything was dealt with quickly - operation followed by chemotherapy, radiotherapy and Herceptin. Staff were always very caring and informative.
Extremely positive.
Fantastic. The entire staff of ward 3A at Crosshouse have been amazing. I have been kept fully updated with treatment and get the said treatment when they say I will. I have every faith in the staff here.
Faultless.
Fine.
First class, the speed at which everything progressed was fantastic.
Follow up with my Oncologist at the Beatson I was stressed because a car hadn't been booked and I had to travel there by trains. So I wasn't very well when I got there. I wasn't told I had to phone for a car myself.
From the diagnosis of breast cancer I was very frightened becoming part of this new world, with hospital appointments, treatment etc. All staff involved have been extremely professional and friendly and answer any questions or worries. All services have been excellent.
Generally very good but often treatment which takes only 2-3 minutes to administer requires 3-4 hours in outpatient department. This is due to pharmacy time to prepare and deliver chemo and other medication. The care and treatment I received was first class.
Good
Good after everything was arranged
Good.
Good.
Good.
Good.
Good. Have always felt that staff are rooting for me and keen to get care package in place as soon as possible.
Great! Wonderful!
Helpful and at an acceptable level. Staff at times seemed pressured and there was also a notable sense that communication channels between staff/range of disciplines were uncoordinated. (It seemed some members of staff on the unit didn't have/or take the time to identify or respond to concerns).
Helpful and supportive
I attended today to get my Herceptin treatment. Was delayed for about an hour at the end as only certain members of staff could remove the line from my port and I had to wait till they were available.
I feel I am receiving the best treatment at present.
I found it quite nerve wracking but the Surgeon and Nurses put me at ease.
I had cancer 2002 so can only refer to my treatment then. I had six months treatment 2 by syringe. Due to side effects of this the other 4 were diluted and administered by drip. I had a good experience then.
I think it has improved over the years, as there does seem to be more continuity now.
I was in another ward with pneumonia and one of my cancer doctors made a point of coming to see me each day.
Informative.
Initial experience 10 years ago (Radiotherapy). Current experience: 6 monthly checkups.
It was a very comfortable experience and I felt totally at ease with all the staff in attendance.
Just went for Herceptin/ Appointment on time Treatment administered and finished all within 2 hours. no problems Staff are friendly and kind
Like a home from home, staff good.
Long delay between clinic appointment and receiving chemotherapy tablets.
My recent contact was in a clinic setting. It depends on who you see what this experience is. I have nothing but admiration for the Breast Care nurses, however I do think that some more time could be spent in clinic with medical staff explaining treatment and more importantly side effects
NHS excellent. Treatment started very quickly after diagnosis.

No problems.
Nothing hidden. I know I can't be cured but the way I am treated helps to deal with it easier.
Open-Ended Response
Our local district nurse was so caring and attentive; the girls who came to the island were wonderful. The after-care was really great!
Overall very good, only thing staff are overstretched due to number of patients and shortage of staff. This makes waiting times longer.
Pretty bad. Delay in diagnosis, agreeing treatment options, arranging treatment, poor communication etc. Total lack of ownership as to who was responsible for care. Lack of Consultant medical staff input. Communication of diagnosis, treatment options done by specialist nurses who were unable to answer some questions. Had to press to see consultant to decide best treatment option.
Prompt and efficient. Otherwise only negative is the time factor, it can be a long day.
Quite pleasant thank you.
Service was professional experience personal and attentive
Services have been extremely good.
Services provided were excellent apart from the amount of time spent simply waiting.
Staff are all very friendly and hardworking, they make you feel at ease whilst receiving treatment
Staff very friendly and helpful. Always answered my questions. Supportive staff.
Stages explained really well.
Support nurse very very very excellent!!!
The NHS do so much for cancer in Ayr hospital and Crosshouse hospital, well I think it is so good.
the nurses are very pleasant and very helpful
The surgeon was fantastic as was my cancer nurse and all other professionals I dealt with.
The treatment at hospital has been fine with understanding staff and great backup (non clinical).
There was an inconsistency of standards from one treatment to another.
Things going well but now having some symptoms. How can doctors not be qualified to do things?
Too long waits.
Too much waiting time.
TORTURE. At a very stressful time in my life being diagnosed with cancer was less stressful than the transport issues that I experienced during my treatment.
Treated well by nursing staff, relaxing.
Very attentive. Staff are very focused and supportive. What can hold up treatment is pharmacy and long waiting times in clinic when short staffed.
Very efficient
Very efficient. Transition from diagnosis to surgery and treatment went to time plan. Good relationship with staff at Royal Infirmary, Glasgow and the Beatson. Good support from link nurses.
Very friendly. Appointments to hospital and treatment very quick.
Very good Doctors and Nurses explain procedures well.
Very good, have to wait a while but that's due to the fact there is not enough staff.
Very good.
Very good. Don't keep me waiting past the time of my appointment. Ayr Hospital usually has a bed waiting for me. 48 hours is the time taken for bag to empty.
Very good. No side effects with treatment.
Very good. Looking back I would have liked more info on side effects and advice on long term issues.
Very positive. Had no element of doubt that all concerned had my best interests at heart.
Very professional!
Very satisfactory.
Very well organised, the only problems that have arisen is the length of time waiting in outpatients, most recently 90 minutes after scheduled appointment time. All staff are excellent.

Well co-ordinated, supportive in that no way do you feel that you are being a nuisance.
When receiving chemotherapy at Ayr the staff were accommodating and always asking if I was ok and offering support

For more information on this report or to obtain copies of the full feedback, please contact:

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Chemotherapy
NHS Ayrshire and Arran

Option Appraisal Report

September 2015

Contents

1. Introduction

1.1 Context

An option appraisal (OA) was carried out as part of a review of chemotherapy[1] services in NHS Ayrshire & Arran (NHS A&A). The OA was to determine the service model that will best ensure that the service remains sustainable in the short, medium and long term and continue to meet the needs of Ayrshire and Arran patients living with cancer.

NHS A&A provides chemotherapy treatments for the four major cancer groups (Breast, Colorectal, Lung and Urology) and chemotherapy for Haemato-oncology, with chemotherapy for gynaecological, upper gastrointestinal, head and neck, brain tumours, melanoma and sarcoma cancers are provided by NHS Greater Glasgow and Clyde at the Beatson Oncology Centre.

There are around 8,500 patients living in Ayrshire and Arran with cancer, and in excess of 2,000 new Ayrshire patients are diagnosed with cancer each year. The incidence of cancer is expected to rise by 1.4 per cent each year, largely as a result of an aging population due to people living longer. In addition, improving cancer survival rates, cancer care treatments and early detection of cancer means it is expected that the number of chemotherapy treatments undertaken per week in NHS A&A will increase by around 9 per cent annually.

1.2 Scope

Cancer services within NHS A&A encompass the full spectrum of cancer care and treatment delivered across a variety of settings for those people with a diagnosis of cancer, however this OA is focused on the delivery of chemotherapy services provided at University Hospitals Ayr and Crosshouse.

The scope of the OA does not include chemotherapy services provided in other Health Boards including the Beatson Cancer Centre, or other treatments including radiotherapy or surgery.

[1] Throughout this document “chemotherapy” is used to encompass biological therapies and cytotoxic chemotherapy.

1.3 Current chemotherapy service

Chemotherapy treatment times vary considerably from 5 to 10 minutes for an oral or subcutaneous treatment to several days for a slow releasing infusion. As a result of advances in treatment regimes there has been a general shift towards administering chemotherapy on an outpatient or day case basis with fewer patients requiring hospital admission.

The majority of patients receiving chemotherapy treatments have this delivered in a specialised chemotherapy chair within one of Ayrshire's District General Hospital's day units.

Chemotherapy day case and inpatient facilities are provided in Station 15, University Hospital Ayr, which has ten treatment chairs for chemotherapy day cases. Station 15 is the haemato-oncology unit providing inpatient chemotherapy care with twelve inpatient beds of which four are side rooms. Three of these side rooms have been upgraded to isolation rooms for patients identified as having a higher risk of infection.

Ward 3C, University Hospital Crosshouse has twelve treatment chairs and two beds supporting chemotherapy day cases. University Hospital Crosshouse Ward 3A is the haemato-oncology inpatient unit where patients requiring overnight chemotherapy are admitted. The unit has eighteen inpatient beds including six side rooms, of which five have been upgraded to isolation rooms.

Pharmacy support to the service is provided by a team of four whole-time-equivalent pharmacists specialising within oncology services. This team is expected to provide full cover (including cover for planned and unplanned absences) across the two chemotherapy units.

There are Aseptic chemotherapy units on both sites. Whilst the facility at Crosshouse currently meets the required operational standards, the facility at Ayr is inadequate in terms of ventilation and accommodation, so requires significant capital investment to meet current demand.

2. Option appraisal methodology

Option appraisal is a well established, practical technique employed in the public sector to set objectives and create and review options. The technique analyses the various options under consideration by assessing their relative benefits and costs. It is also a form of multi-criteria analysis as, when an option is appraised and reviewed, it is done so against a set of criteria as opposed to making a one-off judgement. Once an option appraisal is completed a preferred option or "direction of travel" is identified and this information can be used to support decision making. The technique is particularly useful in addressing projects that have multiple and loosely defined objectives.

An option appraisal consists of a number of stages which are to be worked through when attempting to complete the process. The stages are listed below alongside a brief description of each stage and what it entails.

Stage 1 – Defining the problem

The first stage in the process is used to clearly outline the problem to be examined as well as the specific objectives that need to be addressed. These objectives are used to define the criteria upon which any assessment of alternative options is considered.

Stage 2 – Generating options

This second stage involves the generation of potential ways of responding to the identified problem. In order to assess the potential costs and benefits of any change in care provision, a 'Status Quo' or 'do nothing' option is usually included, as recommended in UK Treasury Guidance[2]. All possible options are included at this stage.

Stage 3 – Short listing options

To be able to assess a manageable list of alternatives, some of the original options are eliminated. Elimination can occur for a number of reasons, for example clearly excessive costs or the option may be unfeasible from the point of view of implementation. Options are eliminated only after full discussion within the group and agreement has been reached.

[2] "The Green Book" Appraisal and Evaluation in Central Government. Treasury Guidance. London: TSO 2003 Available at: https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent

Stage 4 – Identifying, measuring and valuing benefits

Benefits in an option appraisal are measured by the extent to which each option meets those objectives specified at the outset. This is achieved by defining a range of criteria for assessment. The criteria are then weighted to reflect their relative importance to one another. After defining and weighting the criteria, the group then reviews evidence relating to the criteria for each option. Individuals are then asked to assess each option against each criterion and give a score. The score for each criterion is multiplied by the weight that criterion has attached to it. The weighted score across all the criteria are then summed to provide a total weighted benefit score for each option.

Stage 5 – Costings

Costs include both capital and revenue elements of necessary expenditure. Costs will be discounted as necessary according to UK Treasury guidelines.

Stage 6 – Dealing with risk and uncertainty

Any exercise of this nature requires that a number of assumptions are inherent in the analysis of the costs and benefits associated with each option. Key assumptions are varied to assess the degree of certainty surrounding the selection of a preferred option. Exploring the information in this way improves the robustness of any estimates presented and any subsequent decision analysis.

Stage 7 – Decision analysis

Data on costs and benefits are then brought together and summarised using marginal analysis usually with respect to the status quo/do nothing option.

3. Generating and short-listing options

The process of generating a short list of options, which may be seen as “solutions” to the problem, consists of two stages which are described below.

3.1 Generating a long list of options

A long list of options was created by considering all of the possible ways of ensuring NHS A&A’s chemotherapy services remain sustainable in the short, medium and long term and continue to meet the needs of the population. In order to assess the potential costs and benefits of any change in care provision, a ‘status quo’ or ‘do nothing’ option is also included.

The proposed long list was agreed by the Chemotherapy Review Working Group, and distributed to the option appraisal participants in advance of the first stakeholder meeting on 16 July 2015.

Membership of the Working Group and a list of participants who attended the first option appraisal meeting are available in Appendices 1 and 2 respectively.

The long list of options is available in Appendix 3.

3.2 Short listing

The long list of options was discussed at the first meeting and various changes were made before deciding on a ‘shortlist’ of options which the group wanted to take forward for further appraisal. Five options were removed for the reasons detailed in Appendix 4.

3.2.1 Final short list

Whilst a full two site service was deemed not feasible the group felt an improved two site model should be considered, and so an enhanced status quo option was developed, leaving a final short list consisting of the following four options.

Option 1: Status Quo
Chemotherapy prescribing activity on two sites and haematology inpatient service on two sites.

All services provided at both Ayr and Crosshouse with the following exceptions:

- Colorectal outpatients, Crosshouse only
- Lung, new outpatients, Ayr only
- Urology, Ayr only

Option 2: Enhanced Status Quo
All services at both Ayr and Crosshouse Hospitals with the only exception being Uro-oncology which would be provided at the Ayr hospital.

Improved facilities in both hospitals as detailed below:

- Increased number of side rooms on each hospital site
- Provision of observation areas in the day units
- Larger waiting areas in each of the day units
- Increase in the number of consultation rooms
- Reduction in the number of different tasks taking place in treatment preparation areas
- Increase in chemotherapy capacity –either via increased number of chemotherapy chairs or extended chemotherapy delivery times
- Additional space in both hospitals to accommodate additional specialist oncology clinics
- Increased specialist clinical staffing resources: pharmacy, nursing and oncologists

Option 3: Centralisation (Ayr)
All chemotherapy prescribing activity and haematology inpatients centralised in Ayr.

The following services will be centralised:

- All Chemotherapy prescribing and administration – inpatient and outpatient
- All Haematology Inpatient activity
- Haemato-oncology

The following services will continue to be delivered on the current sites:

- Diagnostic clinics and investigations
- Surgery
- Follow up
- Haematology – non oncology outpatients
- Emergency oncology admissions

Option 4: Centralisation (Crosshouse)
All chemotherapy prescribing activity and haematology inpatients centralised in Crosshouse.

The following services will be centralised:

- All Chemotherapy prescribing and administration – inpatient and outpatient
- All Haematology Inpatient activity
- Haemato-oncology

The following services will continue to be delivered on the current sites:

- Diagnostic clinics and investigations
- Surgery
- Follow up
- Haematology – non oncology outpatients
- Emergency oncology admissions

4. Criteria weighting

In order to formally appraise or review the shortlisted options described above, it is important to determine how well the options perform against a set of pre-determined criteria. Therefore, criteria may be viewed as a set of considerations that participants want to take into account when assessing the benefits of each option.

The “Criteria Weighting” stage of the option appraisal consists of two parts, firstly the participants are required to identify and define criteria which they feel are relevant to this particular option appraisal. Secondly, participants are required to weight the criteria and assess their relative importance to each other. Both these stages are described below.

4.1 Criteria definitions

A draft list of seven criteria was circulated to the participants prior to the first option appraisal meeting on 16 July 2015. The draft criteria definitions (available in Appendix 5) were reviewed by participants and a final set of eight criteria was agreed by the group and is detailed below.

Effective
The option should ensure service users receive high quality evidence based care from staff who are able to perform their specialist roles effectively; the service should be capable of realising strategic objectives/standards at national, board and partnership level. The option should help bring about improvements in the health/outcomes of the local population. The option should avoid unnecessary duplication of services already provided to residents in the area.

Safe
The option should be safe for all patients, carers, visitors, and staff. Clinical risk associated with the service should be assessed, managed, and minimised so that provision of the service should do no harm and aim to avoid preventable adverse events.

Integrated
The option should promote integration within Cancer services, with other NHS services and with partner agencies. This should improve inter-relationships between the key departments being considered, and enable better working relationships between staff groups.

Person-centred
Any transfer of services should consider the impact on;

- access to chemotherapy services and patient flow through the care pathway from the patients' perspective, for example avoiding unnecessary waiting for patients both before and during appointments
- Provision of detailed information about treatment to ensure patients/carers can be fully involved in decisions about their care.
- physical space allowing family members to be present during treatment
- continuity of service

Sustainable
The option should meet the need of the local population and be able to accommodate changes in patterns of care and the changing needs of the population over the longer term. It should enable optimal and efficient deployment of all types of resources including staff, facilities and equipment to meet any expansion or contraction of the service in the future.

Supports staff recruitment, retention & development
The option should support the recruitment and retention of high calibre staff both now and in the future. This should consider rotas, training and accreditation.

Minimises impact / disruption
The option should minimise the degree of disruption and impact to the service as well as associated services. Consideration should be given to the clinical interdependencies of the service and whether option would disrupt other parts of the organisation.

Accessible
The option should ensure that patients can access all appropriate care and support, including psychology, social work, AHPs, nursing, medical and pharmacy and should minimise patient travel, particularly for those with disability or mobility problems.

4.2 Criteria weightings

Once criteria were agreed, participants were asked to allocate or "share" 80 points across the eight defined criteria to reflect their relative importance, i.e. attributing more points to the criteria they believed were most important, and fewer points to the criteria they felt were less important.

From these individual scores average criteria weights were calculated, and it is these criteria weights, displayed in Table 1 below, that were taken forward into the analysis.

Table 1: Mean criteria weights for use in analysis

	Mean Weight
Effective	**14**
Safe	**15**
Integrated	**8**
Person-centred	**11**
Sustainable	**10**
Supports staff recruitment, retention & development	**9**
Minimises impact / disruption	**6**
Accessible	**6**

In total 39 people participated in the criteria weighting process, and a list of participants is presented in Appendix 2.

5. Option scoring

The scoring stage of the option appraisal process involves marking each of the shortlisted options out of ten against how well they perform against each of the defined criteria. In order to assist with the scoring process participants received an evidence pack prior to the scoring event.

Once all participants completed the scoring exercise, the scores were combined with the criteria weights to calculate weighted benefit scores (WBS).

5.1 Scoring exercise

Prior to the second stakeholder meeting on 19 August 2015 all participants received an evidence pack which provided information to inform the scoring. The evidence pack included a description of the shortlisted options and information regarding each of the four shortlisted options in relation to the eight criteria.

To ensure all participants had fully understood the evidence in the pack participants were given the opportunity to ask the facilitators any questions that would help clarify any issues regarding the options, criteria or evidence.

The scoring session was facilitated by Kirstin Dickson (Head of Service, Planning and Performance). The participants were asked to score each of the options in turn by providing a mark out ten reflecting how well each option performed against each criterion. Throughout the process participants were able to ask questions regarding clarification of the options or evidence, or the scoring process itself.

In total 36 people scored the options and a full list of participants is presented in Appendix 6.

5.2 Weighted benefit scores (WBS)

The previous section outlined how the scores for each option were generated by asking participants to provide a mark out of ten regarding how well they felt each option performed against each criterion. As each option is scored out of ten across the eight criteria, the maximum total score which could be attributed to each option for each criterion is 80. Scores such as these are referred to as “crude scores” since they do not include the impact of the criteria weightings. The average crude scores found for each of the options is available in Appendix 7.

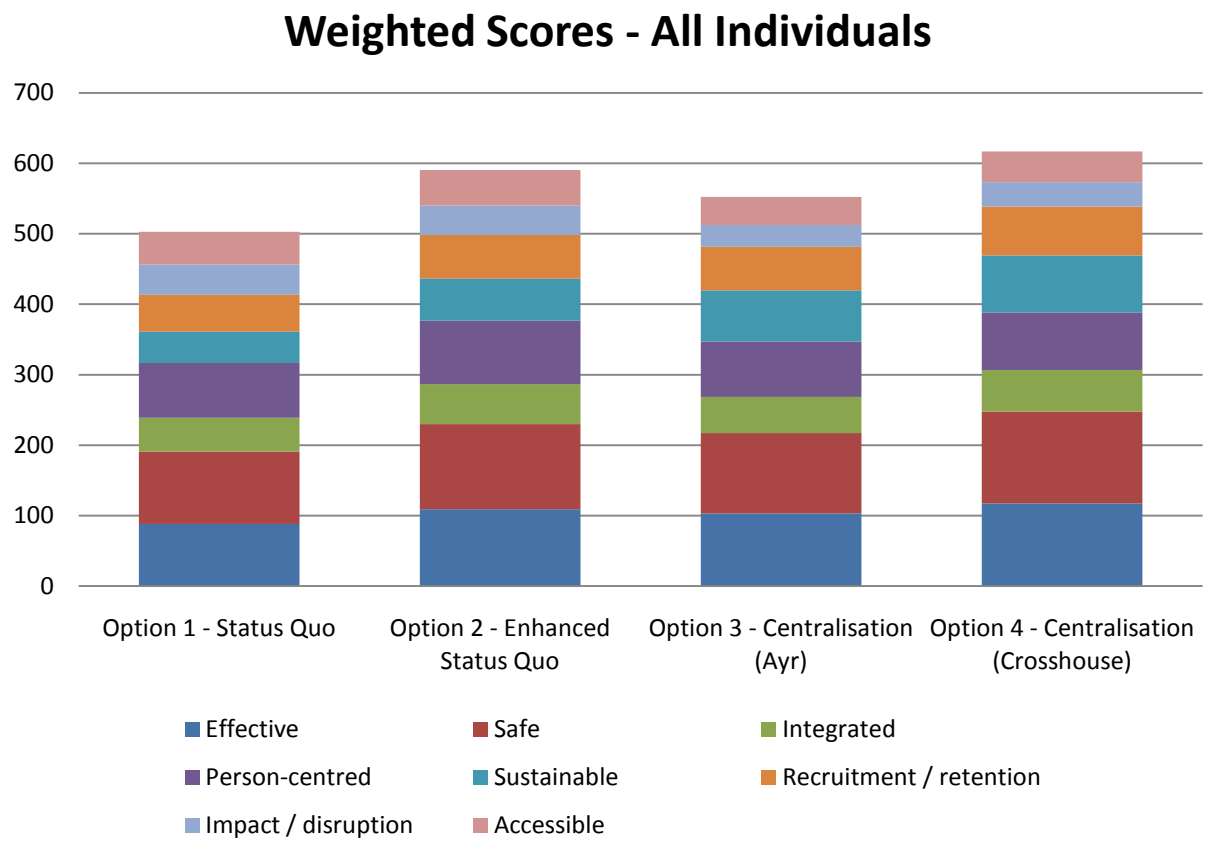
To calculate the weighted benefit score (WBS) for each option, each participant’s score for each criterion was multiplied by the relevant criteria weight. This information was then summed across all eight criteria, and each of the participants, to provide a total WBS for each option.

This methodology ensures that each individual involved in the process was provided with equal influence. The final WBS for the group are shown in Table 2, whilst Figure 1 presents them graphically, showing the importance given to each criterion in the cumulative weighted score for each option.

Table 2: Weighted benefit scores for use in base case analysis

	Weighted benefit score
Option 1: Status Quo	503
Option 2: Enhanced Status Quo	591
Option 3: Centralisation (Ayr)	552
Option 4: Centralisation (Crosshouse)	617

Figure 1: Weighted scores for each option by criterion



6. Costing

In order to undertake decision analysis it is necessary to generate high-level costs for each option under consideration.

Finance and estates colleagues were involved in generating revenue costs; including staffing, rates, heating and cleaning costs, and capital costs; those costs associated with refurbishment, renovation or upgrade of ward areas. All the costs generated are high-level cost estimates.

The majority of revenue costs for each option are staffing costs, and it is the case that options 2, 3 and 4 all require additional staffing in comparison to the status quo (option 1). Whilst this is a relatively small additional cost in options 3 and 4 it is in excess of £600,000 per annum for option 2.

All four options would require significant capital investment in refurbishment and renovation. The refurbishment and renovation costs for option 1 reflect the minimum level of investment to maintain the current level of service delivery.

From these costs a net present value of the total investment over the lifetime of the renovation is created. For this purpose the lifetime of any refurbished ward area is considered to be 40years, and all future costs are discounted by 3.5% to 2015 values.

The high-level costs and NPV for each option are presented in table 3 below.

Table 3: Total high-level costs and net present value (NPV) for each option

	Capital costs	**Revenue costs**	**NPV (40 years)**
Option 1: Status Quo	£3,207,769	£3,920,762 p.a.	£89,866,402
Option 2: Enhanced Status Quo	£5,173,706	£4,615,420 p.a.	£107,186,028
Option 3: Centralisation (Ayr)	£7,919,606	£4,115,242 p.a.	£98,876,761
Option 4: Centralisation (Crosshouse)	£6,359,681	£4,003,936 p.a.	£94,856,696

7. Decision analysis

Table 4 below presents all the data required for the base case analysis. This includes the WBS for each of the options and the associated cost (NPV).

Table 4: Base Case Analysis– costs and benefits of each option

Option	Total WBS	Cost (NPV)(£)	Cost per benefit point (£)	Incremental cost (£)	Incremental benefit	Inc. cost per benefit point (£)
4	617	94,856,696	153,737	4,990,294	114	43,780
2	591	107,186,028	181,486			
3	552	98,876,761	179,049			
1	503	89,866,402	178,653			

In the table above the shortlisted options are listed in order of WBS; in other words in order of the benefit they will provide according to all participants who took part in the scoring exercise. Option 4 is therefore top, with a WBS of 617, followed by options 2, 3 and 1 in that order.

In order to identify the preferred option it is necessary to start at the bottom of the table calculate the incremental cost per benefit point to determine whether a move from option 1 to the next option up the table is worth the additional cost. This is done by comparing incremental cost per benefit point with what the service is currently willing to pay per benefit point; the £178,653 paid for each benefit point in the status quo.

In this case it is possible to simplify the analysis, as it can be seen that option 4 offers greater benefit then options 2 and 3 (617 is greater than both 591 and 552) and is less costly (£94.9m is less than £107.2m and £98.9m). Option 4 is said to dominate both options 2 and 3 and so these options can be eliminated, leaving only the question of whether a move from option 1 to option 4 offers value for money.

Option 4 costs an additional £4,990,294 than option 1, but also provides an additional 114 benefit points. The cost of each additional point is therefore £43,780 (the 'incremental cost' divided by the 'incremental benefit'). Since the incremental cost per benefit point of £43,780 is less than the £178,653 the service is currently willing to pay, a move to option 4 is justified.

Option 4 is the preferred option.

8. Sensitivity analysis

Any exercise of this nature requires that a number of assumptions are inherent in the analysis of the costs and benefits associated with each option. Within the sensitivity analysis, key assumptions are varied to assess the degree of certainty surrounding the selection of a preferred option. Exploring the information in this way helps to establish the robustness of the results presented within the decision analysis.

8.1 Variation between participant groupings

A total of 48 individuals participated in the options appraisal, 39 of whom weighted the criteria and 36 of whom scored the options. These individuals were split into the following categories;

- Patient representatives
    - This group included patients and representatives of support organisations
    - This group comprised 10 individuals
    - Of this group 8 individuals weighted the criteria, and 9 scored the options
- Clinicians
    - This group included all clinicians and consultants who participated, including those from other specialties and those external to NHS A&A
    - This group comprised 9 individuals
    - Of this group 6 individuals weighted the criteria, and 6 scored the options
- Nurses
    - This group comprised 10 individuals
    - Of this group 7 individuals weighted the criteria, and 9 scored the options
- Management staff
    - This group comprised 10 individuals
    - Of this group 10 individuals weighted the criteria, and 6 scored the options
- Other staff
    - This group included Scottish ambulance service staff, laboratory staff, pharmacy staff, allied health professionals and support staff[3].
    - This group comprised 9 individuals
    - Of this group 8 individuals weighted the criteria, and 6 scored the options

[3] Given the small numbers of participants from each of the constituent designations within this group it is inappropriate to split the other staff group further, as this could risk participant's anonymity in scoring.

8.1.1 Differences in WBS

There were differences between the WBS attributed to the options between these groupings, and in some instances differences in the ranking of options by WBS. The ranking and WBS by groupings are displayed in table 5 below. It should be noted that the differences in scores between groupings for an option may not necessarily reflect strength of opinion. For example the 116 point difference between the score for option 3 between clinicians and nurses does not imply that nurses rate that option 116 points 'better' than clinicians; it can be seen that nurses and clinicians both rate the option third some way behind options 2 and 4, and so the difference is more likely to indicate clinicians as a group tended to score all criteria for all options more conservatively than nurses.

Table 5: Ranking and WBS by participating groupings

Option	Ranking / (weighted benefit scores)						
	Clinicians	Nurses	Mgt	Other staff	All staff	Patients	All participants
1	4 (455)	4 (521)	4 (489)	4 (452)	4 (483)	4 (566)	4 (503)
2	2 (560)	1 (660)	3 (503)	3 (538)	2 (575)	1 (640)	2 (591)
3	3 (459)	3 (575)	2 (504)	2 (546)	3 (527)	2 (627)	3 (552)
4	1 (567)	2 (634)	1 (604)	1 (655)	1 (617)	3 (618)	1 (617)

From table 5 it can be seen that three of the five sub-groupings give the highest WBS to option 4 (centralisation at Crosshouse), in line with the total WBS for all participants. All sub groups give the lowest WBS to option 1, suggesting a strong mandate for change from the status quo.

The nursing group attaches a higher benefit to option 2 (enhanced status quo), at odds with other staff groups and the overall scores for all staff and all participants. The patient group also attaches a higher benefit to option 2 than option 4, and in addition attaches a higher benefit to option 3 (centralisation at Ayr), ranking option 4 third by WBS. The

ranking of the centralisation at Ayr option above that of Crosshouse is particularly interesting, as it is at odds with all staff groups, all of whom rated the benefit of the Crosshouse option significantly higher than that of Ayr. This therefore merits further investigation.

Given the relatively small number of scoring participants in the patient group (nine) it is possible for relatively few individuals with strong preferences to skew the results toward their preference. Indeed, in this case the removal of one individual's weightings and scores alters the ranking of options by WBS, as shown in table 6 below.

Table 6: Patients' WBS

	WBS for all patient representatives	**WBS with one individual's weights and scores excluded**
Option 1: Status Quo	566	548
Option 2: Enhanced Status Quo	**640**	**622**
Option 3: Centralisation (Ayr)	627	612
Option 4: Centralisation (Crosshouse)	618	618

Table 6 shows that the removal of one individual's scores reduces the strength of preference for option 2; it still attracts the highest WBS, but is 4 points above option 4 where with all patient representatives included there is a 22 point difference between these options. Additionally the removal of the same individual's scores reduces the WBS of option 3 by 15 points, reversing the ranking of the two centralisation options, so it can be concluded that the majority of patients attach a higher benefit to option 4 than option 3, although this is not reflected in the WBS for all patients. The weights and scores of the individual whose scores are removed for this example are included in all other analysis involving the patient group throughout this report.

8.1.2 Nurses and patients' preferred option

Whilst nurses and patients rank option 2 higher by WBS it does not follow that this is their preferred option when costs are allowed to influence the analysis. The analysis below follows the same steps outlined in section 7 for all participants, but using only the weights and scores of the relevant sub-group.

Table 7: Sensitivity Analysis – Nurse sub group

Option	Total WBS	Cost (NPV)(£)	Cost per benefit point (£)	Incremental cost (£)	Incremental benefit	Inc. cost per benefit point (£)
2	660	107,186,028	162,501	12,329,333	26	478,293
4	634	94,856,696	149,657	4,990,294	113	44,330
3	575	98,876,761	172,078			
1	521	89,866,402	172,404			

As in the base case analysis, table 7 above displays the shortlisted options in order of WBS; in other words in order of the benefit they will provide according to the nurses who took part in the scoring exercise.

Incremental cost per benefit point is used to determine whether a move to the next option up the table offers value for money by comparing it to what the service is currently willing to pay per benefit point; in this case the £172,404 currently paid for each benefit point in option 1.

As before it is possible to simplify the analysis, as it can be seen that option 4 dominates option 3; it offers greater benefit then options 3 and is less costly. Option 3 can therefore be eliminated.

Option 4 costs £4,990,294 more than option 1, but also provides an additional 113 benefit points. The cost of each additional point is therefore £44,330 (the 'incremental cost' divided by the 'incremental benefit'), and since this is less than the £172,404 the service is currently willing to pay per benefit point, a move to option 4 is justified.

A move from option 4 to option 2 is not, however, as each of the additional 26 benefit points (660 – 634) costs £478,293; considerably more than the £172,404 the service is currently willing to pay per benefit point.

Option 4 is the preferred option of the nurse sub-group.

Table 8: Sensitivity Analysis – Patient sub group

Option	Total WBS	Cost (NPV)(£)	Cost per benefit point (£)	Incremental cost (£)	Incremental benefit	Inc. cost per benefit point (£)
2	640	107,186,028	167,569	12,329,332	22	567,228
3	627	98,876,761	157,694	4,020,065	9	441,900
4	618	94,856,696	153,510	4,990,294	51	96,977
1	566	89,866,402	158,646			

In the patient sub-group there are no dominant options, as the options are ranked in order of decreasing cost. The incremental cost per benefit of a move from option 1 to option 4 is £96,977 per point, and as this is less than the £158,646 the service is currently willing to pay per benefit point a move to option 4 does offer value for money.

The incremental cost per benefit of moving from option 4 to option 3 is £441,900, and so a move to option 3 is not justified. As option 3 has now been eliminated the incremental cost of a move from option 4 to 2 is considered, and again the £567,228 is higher than the £158,646 the service is currently willing to pay per benefit point, so a move from option 4 to option 2 is also not justified.

Option 4 is the preferred option of the patient sub-group.

8.2 Varying time horizon

As previously discussed a time horizon of 40 years was applied to calculate the NPV of each option. This period is comparable with the 'lifetime' figures of both Crosshouse and Ayr hospitals used within the NHS A&A's accounts, and also with figures used for calculating depreciation of new build / renovation projects undertaken by NHS A&A.

Nevertheless, there are elements of any refurbishment and renovation required in the shortlisted options that may have significantly shorter lifetimes. As such sensitivity analysis was undertaken to assess the impact of varying the 40 year time horizon. This analysis demonstrated that there is no realistic time horizon that affects the analysis and preferred option.

8.3 other considerations

8.3.1 Weighting sub-groups

It is possible within an OA that one sub-group may outnumber other groups, and so have a proportionately larger influence on the outcome, however all sub-groups in this case are of approximately equal size.

Indeed the two groups with the larger number of scoring participants are nurses and patients with 9 scoring participants each compared to 6 in each other group. Therefore the use of weighting to equalise the impact each group has would act to lessen those two group's impact, thereby reinforcing the higher WBS attributed to option 4 by the other three groups.

Considering all NHS staff as one group and patients as the other it is possible to adjust patient's weightings and scores to give the patient group equal weighting to the staff group. This is achieved by multiplying each patient weighting by 3.875 (to give the 8 patients who weighted options parity with the 31 staff who weighted) and each score by 3 (to give the 9 patients who weighted options parity with the 27 staff who weighted). This does not change the ranking by WBS of the options and therefore does not alter the preferred option.

8.3.2 Variation in capital costs

It was previously mentioned that the costs used in the analysis were high-level figures, and so the exact spend on refurbishment and renovation of ward areas may vary from the estimate when building work is undertaken.

It is possible that significant variation of cost estimates could alter the preferred option of an OA, and it was shown in table 3 that there is reasonably wide variation between options in this OA in terms of capital investment required.

It is therefore worthwhile considering the impact of these differences on the OA outcome. In this case, however, even using a capital cost of three-times the £6.4m figure for option 4 (making it far in excess of double the capital investment of the next most expensive option) would not alter the outcome and option 4 would remain the preferred option.

8.3.3 Strategic scoring

It is possible for those taking part in option appraisal to score strategically; that is to systematically score options higher or lower, irrespective of the evidence, in order to increase or decrease the likelihood of that option emerging as the preferred option.

There is very limited evidence of any strategic scoring in this OA.

9. Conclusion

The aim of this option appraisal was to identify a preferred option for the delivery of chemotherapy services in NHS Ayrshire & Arran.

A number of options were considered and formally appraised, and option 4; the centralisation of all chemotherapy prescribing activity and haematology inpatients in University Hospital Crosshouse, was identified as the preferred option.

The selection of option 4 as the preferred option was reflected in all sub-groups, and in all sensitivity analysis.

APPENDIX 1 – Membership of the working group

Name	Title
Nicky Batty	Macmillan Practice Development Facilitator
Moray Baylis	Trainee Health Economist
Noreen Caldwell	Local Officer, Scottish Health Council
Kirstin Dickson	Head of Service - Planning & Performance
Diane Graham (to June 2015)	Quality Improvement Lead (Person-centred Care)
John Jackson	Patient Representative
Peter MacLean	Lead Cancer Clinician
Alex McGuire	Cancer Services Manager
Liz Moore	Director of Acute Services
Caroline Rennie	Macmillan Nurse Consultant
Elaine Savory	Equality and Diversity Project Manager
Irene Wilson	Person Centred Care Manager

APPENDIX 2 – Stakeholder meeting 1 record of attendance

Chemotherapy option appraisal meeting 1: weighting meeting, 16 July 2015

Participants

Name	Title
Karen Andrews	General Manager, Surgical
Nicky Batty	Macmillan Practice Development Facilitator
Elma Bomphrey	Patient Representative
Mike Boyle	Clinical Nurse Manager
Wendy Byars	Charge Nurse, Station 15, Ayr
Sharon Campbell	Clinical Nurse Manager
David Dodds	Clinical Director, Beatson Oncology Centre
Joanne Edwards	Assistant Director of Acute Services
Cara Garven	Patient Representative
Janice Gillan	Head of Clinical Support Services, East
Julie Gillies	Consultant Haematologist
James Goodwin	Scottish Ambulance Service
Maria Goodwin	Haematology Clinical Nurse Specialist
Jean Hendry	Assistant Director Acute services, Crosshouse
Philip Hodkinson	Clinical Lead, Lung Cancer
John Jackson	Patient Representative
Roisin Kavanagh	Lead Pharmacist, Crosshouse
Paul Kerr	Clinical Director, North Ayrshire Partnership
Joyce Lang	Clinical Director, Laboratory Services
David Mackintosh	Scottish Ambulance Service
Peter MacLean	Lead Cancer Clinician
Nick MacLeod	Consultant, Oncology
Sandra McCall	CEO, Ayrshire Cancer Support
Alex McGuire	Cancer Services Manager
Judith McKee	Charge Nurse, Ward 3A/C, Crosshouse
Susanne McNaught	Patient Representative
Gail McSheehy	Clinical Team Leader, District Nursing
Liz Moore	Director of Acute Services
Karen Munro	General Manager, Women, Children and Diagnostic Services
Maureen Murray	Dietetic Lead, Integrated Services – South
Paul Noble	Staff Nurse, Station 15, Ayr
Irene Peacock	MacMillan Dietitian
Caroline Rennie	Macmillan Cancer Nurse Consultant

Irene Riddell	Patient Representative
Aileen Roy	Cancer Nurse Specialist, Colorectal
Lucy Scott	Visiting Consultant Oncologist
Andy Slater	Patient Representative
William Steele	Patient Representative
Gillian Wishart	Principal Pharmacist, Cancer Services

In attendance

Name	**Title**
Moray Baylis	Trainee Health Economist
Lorraine Brady	Trainee Health Economist
Noreen Caldwell	Local Officer, Scottish Health Council
Kirstin Dickson	Head of Service - Planning & Performance
Jeff Holt	Area Manager, Scottish Health Council
Helen Mosson	Head of Clinical Support Services, South
Robert Stobbs	Hotel Services Manager, South

APPENDIX 3- Draft long list of options

Status Quo

Chemotherapy prescribing activity and haematology inpatient service on two sites. All services provided at both Ayr and Crosshouse with the following exceptions;

- Colorectal outpatients, Crosshouse only
- Lung, new outpatients, Ayr only
- Urology, Ayr only

Centralisation (Ayr)

All chemotherapy prescribing activity and haematology inpatients centralised in Ayr.

- The following services will be centralised:
  - All Chemotherapy prescribing and admin – inpatient and outpatient
  - All Haematology Inpatient activity
  - Haemato-oncology
- The following services will continue to be delivered on the current sites:
  - Diagnostic clinics and investigations
  - Surgery
  - Follow up
  - Haematology – non oncology outpatients
  - Emergency oncology admissions

Centralisation (Crosshouse)

All chemotherapy prescribing activity and haematology inpatients centralised in Crosshouse.

- The following services will be centralised:
  - All Chemotherapy prescribing and admin – inpatient and outpatient
  - All Haematology Inpatient activity
  - Haemato-oncology
- The following services will continue to be delivered on the current sites:
  - Diagnostic clinics and investigations
  - Surgery
  - Follow up
  - Haematology – non oncology outpatients
  - Emergency oncology admissions

Centralisation (new build)

All chemotherapy services centralised in a purpose built cancer centre.

Hybrid Model
Deliver chemotherapy in Ayr and Crosshouse Hospitals but with each site providing distinct centralised services based on tumour type or mode of delivery (inpatient vs daycase)

Full two site service
Extend both current sites service to offer provision of full range of services at both Ayr and Crosshouse.

Local provision
Local 1 - all outpatient chemotherapy delivered in patient's home, with a hospital based ward for inpatient and specialist (ie clinical trials) chemotherapy.
Local 2 - all outpatient chemotherapy delivered at the nearest health centre, community hospital or hospital chemo unit, with a hospital based ward for inpatient and specialist chemotherapy.
Local 3 - the majority of outpatient chemotherapy delivered at a centralised chemotherapy unit with a small number of local delivery options for patients living far from the unit.

Outsource Chemotherapy Delivery
All chemotherapy services to be delivered outwith NHS Ayrshire and Arran. Services to be provided either from another NHS provider (e.g. NHS Greater Glasgow and Clyde) or a private provider (e.g. Healthcare at Home).

APPENDIX 4 – Rationale for removal of non-shortlisted options

Centralisation (new build)

- It would be prohibitively expensive to build a new cancer centre on a non-hospital site. It is also a safety and continuity of care issue to have cancer services not co-located with a hospital.

Hybrid Model

- A hybrid model would potentially involve significant service re-organisation without solving any of the cons of the current service delivery model. It could potentially create further issues around co location, continuity of service, and safety.

Full two site service

- It is not feasible to have all services on both sites as it would require a significant increase in staffing requirement. Recruitment for such an increase would be difficult to achieve and would require significant additional costs which would be difficult for the board to afford. Such a service would deliver little additional benefit to service users for the high additional cost.

Local provision

- While the extension of the provision of care in local settings is a reasonable long-term goal, it would be an extension to any hospital-based service model for relatively small number of patients.

Outsource Chemotherapy Delivery

- This option would require a significant contract with the external supplier, whilst making a large number of NHS Ayrshire & Arran staff redundant.

APPENDIX 5 – Draft criteria

The draft criteria detailed below were discussed and amended at the first stakeholder meeting on 16 July 2015. They were superseded by the final criteria detailed in section 4.1 of the report.

Effective
The option should ensure service users receive high quality evidence based care from staff who are able to perform their specialist roles effectively; the service should be capable of realising strategic objectives/standards at national, board and partnership level. The option should help bring about improvements in the health/outcomes of the local population. The option should avoid unnecessary duplication of services already provided to residents in the area.

Safe
The option should be safe for all patients, carers, visitors, and staff. Clinical risk associated with the service should be assessed, managed, and minimised so that provision of the service should do no harm and aim to avoid preventable adverse events.

Integrated
The option should promote integration within Cancer services, with other NHS services and with partner agencies. This should improve inter-relationships between the key departments being considered, and enable better working relationships between staff groups.

Person-centred
The option should ensure that patients can access all appropriate care and support, including psychology, social work, AHPs, nursing, medical and pharmacy.

Any transfer of services should consider the impact on;

- patient travel, particularly for those with disability or mobility problems
- access to chemotherapy services and patient flow through the care pathway from the patients' perspective, for example avoiding unnecessary waiting for patients both before and during appointments
- provision of detailed information about treatment to ensure patients/carers can be fully involved in decisions about their care.
- physical space allowing family members to be present during treatment
- continuity of service

Sustainable
The option should meet the need of the local population and be able to accommodate changes in patterns of care and the changing needs of the population over the longer term. It should enable optimal and efficient deployment of all types of resources including staff, facilities and equipment to meet any expansion or contraction of the service in the future.

Supports staff recruitment, retention & development
The option should support the recruitment and retention of high calibre staff both now and in the future. This should consider rotas, training and accreditation.

Minimises impact / disruption
The option should minimise the degree of disruption and impact to the service as well as associated services. Consideration should be given to the clinical interdependencies of the service and whether the option would disrupt other parts of the organisation.

APPENDIX 6 – Stakeholder meeting 2 record of attendance

Chemotherapy option appraisal meeting 2: scoring meeting, 19 August 2015

Participants

Name	Title
Patsy Alexander	Staff Nurse, Ward 3C, Crosshouse
Karen Andrews	General Manager, Surgical
Nicky Batty	Macmillan Practice Development Facilitator
Elma Bomphrey	Patient Representative
Mike Boyle	Clinical Nurse Manager
Mike Brown	Clinical Nurse Manager
Wendy Byars	Charge Nurse, Station 15, Ayr
David Chung	A&E Consultant
Ian Dalgleish	Patient Representative
Cara Garven	Patient Representative
Julie Gillies	Consultant Haematologist
William Gordon	Consultant Haematologist
John Jackson	Patient Representative
Roisin Kavanagh	Lead Pharmacist, Crosshouse
Paul Kerr	Clinical Director, North Ayrshire Partnership
Joyce Lang	Clinical Director, Laboratory Services
Douglas MacFarlane	Patient Representative
Peter MacLean	Lead Cancer Clinician
Nick MacLeod	Consultant, Oncology
Sandra McCall	CEO, Ayrshire Cancer Support
Alex McGuire	Cancer Services Manager
Judith McKee	Charge Nurse, Ward 3A/C, Crosshouse
Sandra McMahon	Charge Nurse, Interventional Radiology
Susanne McNaught	Patient Representative
Liz Moore	Director of Acute Services
Helen Mosson	Head of Clinical Support Services, South
Karen Munro	General Manager, Women, Children and Diagnostic Services
Maureen Murray	Dietetic Lead, Integrated Services – South
Paul Noble	Staff Nurse, Station 15, Ayr
Irene Peacock	MacMillan Dietitian
Caroline Rennie	Macmillan Cancer Nurse Consultant
Irene Riddell	Patient Representative
Calum Robertson	Staff Nurse, Ward 3A, Crosshouse

Aileen Roy	Cancer Nurse Specialist, Colorectal
William Steele	Patient Representative
Gillian Wishart	Principal Pharmacist, Cancer Services

In attendance

Name	**Title**
Moray Baylis	Trainee Health Economist
Sharon Bleakley	Local Officer, Scottish Health Council
Lorraine Brady	Trainee Health Economist
Kirstin Dickson	Head of Service, Planning & Performance
Jeff Holt	Area Manager, Scottish Health Council

APPENDIX 7 – Crude scores

	Benefit Score
Option 1: Status Quo	51
Option 2: Enhanced Status Quo	59
Option 3: Centralisation (Ayr)	54
Option 4: Centralisation (Crosshouse)	60

Chemotherapy Service Review – Transport Impact Assessment

1. Overview

Due to the expected increase in chemotherapy requirements, a full review of chemotherapy services is required to ensure that chemotherapy services continue to meet the needs of cancer patients and are sustainable in the short, medium and long term. Following a robust option appraisal which included extensive patient, public and staff engagement the preferred option was identified as centralisation of chemotherapy services at University Hospital Crosshouse (UHC). The purpose of the following information is to provide information on the potential impact on travel for patients in relation to centralisation of chemotherapy services at UHC and possible mitigation.

The data presented is retrospective and the future projections for travel impact are based on the assumption that travel patterns will remain unchanged. In normal clinical practice however patient travel arrangements are discussed at a pre-chemotherapy visit or at first treatment, with advice and signposting to volunteer driver organisations made as needed. Irrespective of the proposed changes it is always the staff's objective to minimise the travel impact for patients.

2. Patient/public feedback on chemotherapy services

Patient and public feedback on chemotherapy services was collected between March and April 2015. 120 individuals completed the questionnaire and 70% had a personal experience of cancer. There were an equal number of responses from North (38.2%) and South Ayrshire (40%) with a smaller sample from East Ayrshire (21.8%). Individuals were asked to rank the importance of aspects of care and results as shown below:

1st Quality of care

2nd Good information about care and treatment

3rd Specialists being available in Ayrshire

4th Specialists being local to where you live

5th Distance you have to travel to receive treatment

In 2013, a mode of transport assessment was performed at UHC and University Hospital Ayr (UHA). The questionnaire was completed by 91 individuals:

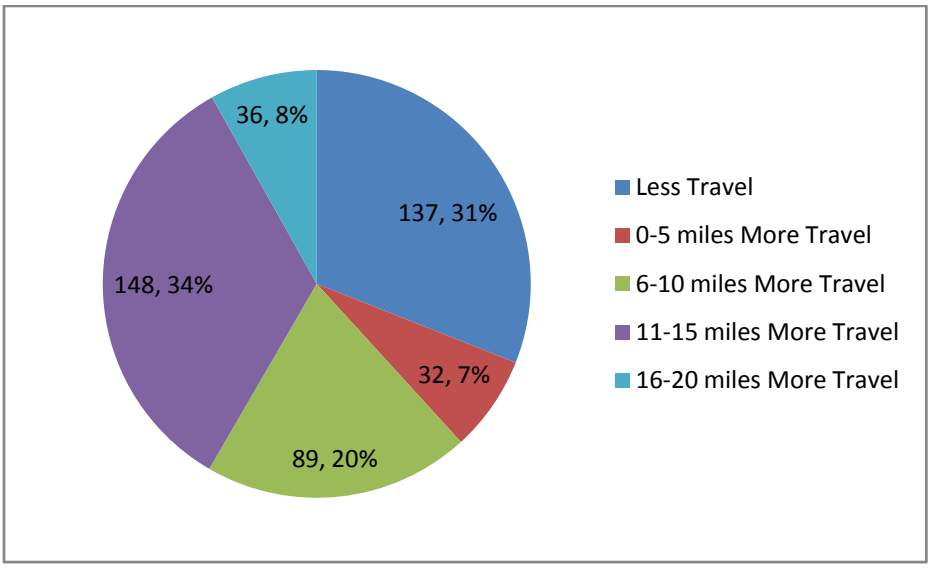
Hospital	Total	Own Car	Family/ Friend Car	Public Transport	Ayrshire Cancer Support (ACS)	Taxi	SAS Patient Transport
Ayr	43	30%	53%	5%	5%	2%	5%
Crosshouse	48	25%	57%	8 %	6%	4%	0%

Chemotherapy Services are currently delivered at both UHA and UHC, however while most patients attend the nearer hospital for Lung, Breast and Haematology chemotherapy, there is currently a single service (based at UHA) for Urology chemotherapy. Colorectal chemotherapy patients attend the clinic provided at UHC prior to chemotherapy delivery at their local hospital. This means that while some patients would have further to travel should all chemotherapy be delivered at UHC, two patient groups would benefit from reduced journeys: Urology patients living nearer to UHC, and Colorectal patients living nearer UHA, as they would only need to attend one hospital site instead of two.

To assess the impact of centralisation of chemotherapy services at UHC on the patient group currently attending UHA for chemotherapy, the postcodes for these patients were reviewed via Chemocare (electronic prescribing system) during 2015 (Appendix 1).

Centralisation of chemotherapy services at UHC would result in: 36 patients (302 appointments) having to travel an additional 16-20 miles, and 148 patients (1103 appointments) having 11-15 miles additional travel. This comprises 42% of the patients currently attending UHA for chemotherapy related treatment. A further 27% would have extra travel distance of less than 10 miles, while 31% would have a reduction in their travel distance.

Changes to travel distances in the event of transfer of Chemotherapy Service from UHA to UHC (Individual patient numbers for 2015)



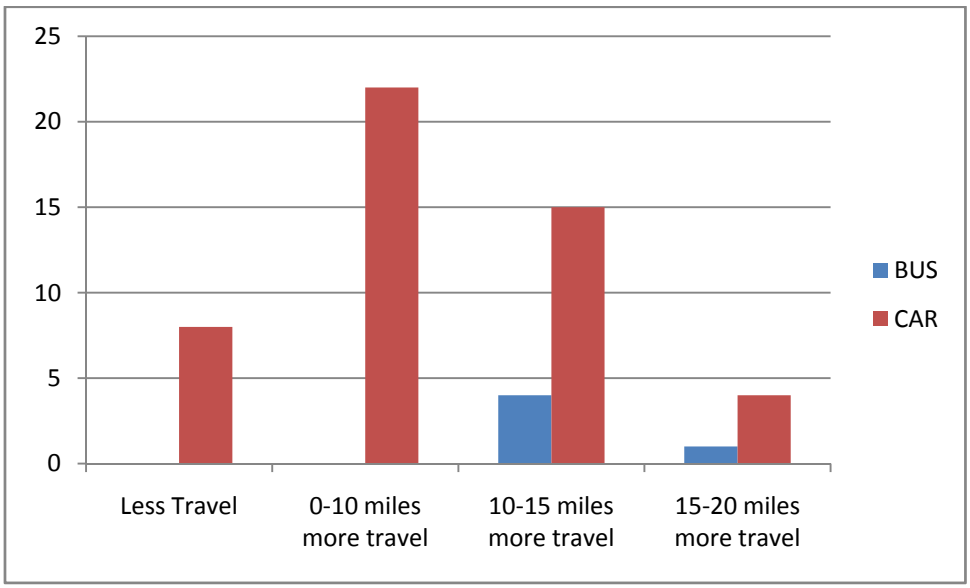
3. Patient Travel Expenses

Chemotherapy patients may be entitled to help with necessary travel costs to and from hospital if they receive NHS treatment under the care of a consultant and have a low income or receive certain benefits or credits. Chemotherapy patients who require information and help with patient travel expenses are directed to their local hospital cash office for assistance.

Between 01/04/15 and 03/03/16 patient travel expense payments were made for 54 journeys.

Looking at these 54 journeys, if chemotherapy services were to be centralised at UHC: for 24 of the journeys travel distance would increase by over 15 miles (of these journeys 5 were made by bus); for 22 of the journeys travel distance would increase by less than 5 miles; and for 7 of the journeys travel would decrease by more than 5 miles.

Figure 1: The Impact on Travel Distance for the 54 Journeys made to UHA for Chemotherapy for which expenses were claimed in the event of that treatment being delivered at UHC



4. Volunteer Driver Services

Appendix 5 lists the volunteer drivers' services which provide assistance to chemotherapy patients travelling to hospital in Ayrshire. Volunteer driver services will pick up patients or visitors and take them to hospital and clinic appointments.

Many of the cancer support agencies providing volunteer driver services do not collect data on whether the patient is specifically attending hospital for

chemotherapy. Ayrshire Cancer Support (ACS) started to provide local volunteer driver services for cancer patients from July 2015. In the last 9 months, ACS has provided 16 return transport journeys to UHA for chemotherapy. If chemotherapy services were to be delivered from UHC, 12 of these 16 journeys would involve less travel and 3 of the journeys would involve additional travel of 15 minutes or more.

5. Public Transport Services

If chemotherapy services were to be provided from UHC the following public transport services provide access to the hospital:

5.1 Train Services

UHC is located 3 km west of Kilmarnock train station. Trains to Kilmarnock railway station are every 60 minutes from Glasgow and Girvan. Staff, patients and visitors can access bus transfer from Kilmarnock bus station which is approximately 5 minutes walk from Kilmarnock railway station. Direct bus services are regularly available from Kilmarnock bus station to UHC (Stagecoach Service 11).

5.2 Bus Services

UHC has two dedicated bus stops located within the hospital site adjacent to the main hospital entrance providing good infrastructure including bus shelters, seating and timetable information. Real time bus timetable information is provided at the hospital bus stops and within the hospital on hospital waiting area information (TV screens).

Appendix 4 provides information on bus routes and frequency of bus services serving UHC.

6. Patient, Staff and Visitor Car Parking - University Hospital Crosshouse

UHC provides 1283 designated Long stay car parking spaces and 536 designated short stay car parking spaces (max 3 hours) along with 96 designated disabled car parking spaces.

NHS Ayrshire & Arran is committed to providing a limited number of dedicated car parking spaces within the Crosshouse site for use by patients attending chemotherapy services and for volunteer driver services supporting transport of patients.

Appendix 6 shows the location and number of car parking spaces at UHC.

7. Summary

Patients' priorities for chemotherapy services focus around quality of care, good information about care and treatment, and specialists being available in Ayrshire.

For 42% of chemotherapy patients currently treated at UHA, centralisation of chemotherapy services at UHC would increase patient travel distance by more than 10 miles each way. The patients most affected by increased patient travel distance would be those living in the South and East of UHA catchment area.

Approximately 10% of patients attending chemotherapy services travel by public transport and these patients would be disproportionately disadvantaged in terms of increased travel – see Appendix 2.

The mode of public transport used by patients to access chemotherapy services can significantly affect whether travel time would increase if chemotherapy services were to be centralised at UHC. For example:

- A patient travelling by train to centralised chemotherapy services at UHC would experience an increased journey time of approximately 20 minutes.
- A patient travelling by bus from Dalmellington to centralised chemotherapy services at UHC would experience an increased journey time of approximately 85 minutes.

Patients living in Cumnock live slightly closer to UHA by car, but UHC is easier to access by public transport.

Patients who are eligible for help with necessary travel costs to and from hospital would continue to receive patient travel expenses, however the amount of money they have to initially pay out in travel costs may increase.

A number of third sector organisations provide local and regional transport support to assist chemotherapy patients' travel to hospital. Ayrshire Cancer Support will continue to provide volunteer driver services to support cancer patients' access to hospital and have pledged to increase their pool of volunteer drivers following their initial pilot period.

To further engage with local people NHS Ayrshire & Arran Lead Cancer team will participate in facilitated discussions during June and August 2016 in the following rural areas of high deprivation: Dalmellington, Girvan and Cumnock.

To assist with chemotherapy patient access to centralised chemotherapy services at UHC and to help mitigate against additional patient travel, NHS Ayrshire & Arran is committed to:

- Providing a limited number of dedicated car parking spaces within the Crosshouse site for use by chemotherapy patients and volunteer driver services transporting patients to chemotherapy services.
- .
- Ensuring that public transport information is available from chemotherapy service reception areas.

Ayrshire Cancer Support is also looking to increase the number of volunteer drivers they have available to assist with transport of patients to chemotherapy services.

Appendices

Appendix 1 – Postcode map of Ayrshire

Appendix 2

The following table illustrates car travel distances and times for South Ayrshire towns. Travel time estimations are derived from Google maps.

Car Travel distances and times for South Ayrshire Towns

Town	Postcode	Travel Distance to UHA (Miles)	Travel Time to UHA (Minutes)	Travel Distance to UHC (Miles)	Travel Time to UHC (Minutes)	Difference in Journey Distance	Difference in Journey time
Dalmellington	KA6	12.4	20	29.7	45	17.3	25
Maybole	KA19	8.5	16	22.6	30	14.1	14
Prestwick	KA9	6.1	14	12.3	21	6.2	7
Newton on Ayr	KA8	4.3	12	13.5	26	9.2	14
Ayr	KA7	3.1	10	15.8	26	12.7	16
Alloway	KA7	3.1	7	16.5	28	13.5	21
Dunure	KA7	7.8	15	23.1	38	15.3	23
Daily	KA19	15.6	27	29.8	46	14.2	19
Girvan	KA26	20.6	35	35.1	58	14.5	23
Ballantrae	KA26	33	52	47	75	14	23
Cumnock	KA18	15.3	24	19	29	3.7	5
Troon	KA10	11.4	21	9	20	-2.4	-1
Mauchline	KA5	12.8	22	10.8	19	-2	-2

Appendix 3

UHC Bus Services, Routes and Frequencies

Service/Operator	Route	Frequency	
		Monday - Saturday	Sunday
11 Stagecoach	Ardrossan – Saltcoats – Kilwinning – Irvine - Kilmarnock	7 -8 minutes	15 minutes
21 Western Buses	UHC – Dreghorn – Irvine	80 minutes	120 minutes
110 Stagecoach	Troon – Dundonald – Kilmarnock	60 minutes (evenings)	No Service
125 Stagecoach	Beith – Dalry – Irvine - UHC	60 minutes (evenings)	No Service
337 Shuttle Buses	Beith – Dunlop – Stewarton - Kilmarnock	120 minutes	120 minutes

Appendix 4

Public Transport Travel Time to UHA and UHC Hospitals from South Ayrshire towns, in minutes

Town	Postcode	Number of Buses to UHA	Travel time by bus to UHA	Number of Buses to UHC	Travel time by bus to UHC	Additional Travel Time in Minutes to UHC	Number of additional bus changes to UHC
Dalmellington	KA6	1	35	3	120	85	2
Maybole	KA19	2	50	3	80	30	1
Prestwick	KA9	2	45	2	40	-5	0
Newton on Ayr	KA8	2	35	2	60	25	0
Ayr	KA7	1	18	2	60	42	1
Alloway	KA7	2	45	3	85	40	1
Dunure	KA7	2	40	3	90	50	1
Daily	KA19	2	75	3	105	30	1
Girvan	KA26	2	60	2	80	20	0
Ballantrae	KA26	3	130	4	180	50	1
Cumnock	KA18	2	90	2	70	-20	0
Troon	KA10	2	60	2	50	-10	0
Mauchline	KA5	2	70	2	45	-25	0

Appendix 5

Volunteer driver services which provide assistance to chemotherapy patients travelling to hospital in Ayrshire

Volunteer Driver Service	Area Serviced
CAN	Girvan and South Carrick
Ayrshire Cancer Support	Throughout Ayrshire
Irvine Cancer Care	Irvine
Beith Cancer Care	Beith
North Ayrshire Cancer Care	Kilwinning to Wemyss Bay except Irvine
Scottish Cancer Care	
ARCas (Ayrshire Cancer Network)	Arran
British Red Cross	Arran and North Ayrshire
BRICC	10 mile radius of Ballantrae

Appendix 6

Location and number of car parking spaces at UHC