Achieving World-Class Cancer Outcomes: Transformation Funding
Application Form Part A

Application details

<table>
<thead>
<tr>
<th>Name of Cancer Alliance submitting this application</th>
<th>Peninsula Cancer Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal contact for this application</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>Lynne Kilner</td>
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<tr>
<td>Job title:</td>
<td>Peninsula Cancer Alliance Programme Manager</td>
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<td><a href="mailto:lynne.kilner@nhs.net">lynne.kilner@nhs.net</a></td>
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<tr>
<td>Phone no.:</td>
<td>07557 015499</td>
</tr>
<tr>
<td>Confirmation of approval by Alliance lead</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>Dr Alison Diamond</td>
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<td>Job title:</td>
<td>Chief Executive, Northern Devon Healthcare NHS Trust</td>
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<tr>
<td>Confirmation of approval by STP lead/s</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>Ethan McCarthy</td>
</tr>
<tr>
<td>Job title:</td>
<td>Director Strategy and Business Development, Royal Cornwall Hospital NHS Trust</td>
</tr>
<tr>
<td></td>
<td>Sonja Manton</td>
</tr>
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<td>Director of Strategy NEW Devon and South Devon and Torbay CCGs</td>
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<tr>
<td>Email:</td>
<td><a href="mailto:ethna.mccarthy@nhs.net">ethna.mccarthy@nhs.net</a></td>
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<tr>
<td></td>
<td><a href="mailto:sonja.manton@nhs.net">sonja.manton@nhs.net</a></td>
</tr>
<tr>
<td>Confirmation of approval by all Alliance members</td>
<td></td>
</tr>
<tr>
<td>Organisations:</td>
<td>• NHS England South West</td>
</tr>
<tr>
<td></td>
<td>• Public Health England South West</td>
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<td></td>
<td>• Northern Devon Healthcare</td>
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<td>• Plymouth Hospitals</td>
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<td>• Royal Cornwall Hospitals</td>
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<td>• Torbay &amp; South Devon</td>
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<td>• Royal Devon &amp; Exeter</td>
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<td>• Kernow CCG</td>
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<td>• NEW Devon CCG</td>
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<td>• South Devon &amp; Torbay CCG</td>
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<td></td>
<td>• Cancer Research UK South West</td>
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<tr>
<td></td>
<td>• Macmillan Cancer Support South West</td>
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</tbody>
</table>

The bids are all constructed to create no recurrent costs now. The Alliance with STPs will monitor impact of the schemes within a timeframe that would allow us to plan to cease any scheme that is not proving of value. The bids include evaluations that will set out the recurrent consequences so STPs can choose whether to commission after the end of the programme (2019/20).
Leadership, Governance and Partnership Arrangements
This section outlines some other important questions required to assess your bid.

<table>
<thead>
<tr>
<th>Leadership, Governance and Partnership Arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please describe the governance arrangements you would put in place to oversee the transformation work.</td>
</tr>
<tr>
<td>The Governance arrangements for the transformation work are designed to drive forward large scale change at pace through whole system partnership working, clear leadership and accountability, and robust programme management to support delivery.</td>
</tr>
<tr>
<td>For Devon and Cornwall the Transformation Programme will be overseen by the Peninsula Cancer Alliance Board. This Board is chaired by an executive lead with clinical leadership provided by a Consultant Surgeon. Membership also includes senior commissioning, management, clinical representation from all constituent organisations from across the cancer pathway (from prevention through to end of life care) and patient representatives. The Board has an identified lead for each STP area: the 2 STP areas have recently created their own cancer delivery groups, with developing work plans based on the Alliance work plan and reflecting local issues.</td>
</tr>
<tr>
<td>The subgroups of the Board include Living With and Beyond Cancer (LWBC) – encompassing the recovery package and risk stratified pathways. They will report regularly and be the approval process for required progress reports. To create system change at pace, we will form short-term task and finish style work streams within the overall Transformation Programme-these will sit under the Board LWBC subgroup.</td>
</tr>
<tr>
<td>Leadership and accountability within the Trusts will be primarily through the lead nurses with a clear mandate to work on a Peninsula wide basis and to the agreed metrics. We will appoint a GP lead to support the LWBC subgroup and particularly for the Primary care facing elements of the programme.</td>
</tr>
<tr>
<td>For operational purposes the Alliance is led by the South West Cancer Network manager and a programme manager within NHS England South West. The link to NHS England will be instrumental in driving forward change across the Alliance, enabling and supporting development as well as ensuring STPs and individual organisations accountability against the metrics and the terms of the bid. The relevant clinicians have been involved in the development of this bid, are supportive and will form part of the ongoing governance arrangements.</td>
</tr>
<tr>
<td>Please describe how your governance arrangements outlined above are part of the wider STP governance arrangements to ensure joined up working and a collective commitment.</td>
</tr>
<tr>
<td>The Alliance Board contains the executive lead for cancer for both STPs The Peninsula Cancer Alliance has been endorsed by the STPs as the cancer work stream of the STPs and is therefore embedded in the STPs and the Alliance work plan is part of the wider context and aligned with local levers and funding.</td>
</tr>
<tr>
<td>The Cancer Alliance Board chair and several other members of the Board are also members of other STP work streams which significantly interlink with the cancer agenda, such as elective care,</td>
</tr>
</tbody>
</table>
Leadership, Governance and Partnership Arrangements

Long term conditions, end of life/palliative care. They can therefore represent the cancer agenda as well as feedback other developments relevant to cancer care.

This vision and proposal closely aligns with the work of all the STPs in this area. There is a commitment from each STP in their prioritisation of cancer services, as supported by the Five Year Forward View.

This is also reflected in the work plans of the cancer groups operating at an STP level.

Delivery of this proposal will be embedded into the STP work, by the flow of funding from the Alliance to the STP who will attribute the funding and resources amongst the services. The Alliance will have a service level agreement with each STP for the delivery of the outcome agreed in this bid.

By this authority, the Cancer Alliance will act as the decision-making body and make real and impactful decisions in relation to the planning and delivery of the Cancer Taskforce strategy locally. Accountability will be to the same regional structures as our STPs.

Please describe how you would involve wider partners to design and support delivery of transformation.

We have a good track record of partnership working and there are existing exemplars both locally and nationally from which we will draw learning, such as the Somerset ACE programme and the FORCE and Macmillan recovery package project in Exeter: the original recovery package has been modified to reflect patient feedback and national directives such as ESC.

Macmillan Cancer Support and the Somerset Cancer Registry are major partners in our current work and will be in the Transformation Programme, along with other local organisations such as Force, the Mustard Tree and the Macmillan Cove Centre in Cornwall.

Macmillan has extensive experience in working collaboratively to design and implement new programmes of work across early diagnostics, the recovery package and stratified follow-up pathways through partnership working. As a result, we now have this learning and a variety of resources that they have offered to share with us to support us through this transformation programme.

The Alliance held a patient and public engagement event in July with local patient representatives and local charities to refresh our approach to engaging with patients and the wider public, to ensure engagement is meaningful, is representative, and will contribute to tackling inequalities.

The Transformation Programme will be supported by an engagement plan and will connect with local authorities, the voluntary and community sector and wider stakeholders. The Alliance will ensure in particular early and ongoing engagement with Health and Wellbeing Boards throughout the footprint. We will also use existing patients
<table>
<thead>
<tr>
<th><strong>Leadership, Governance and Partnership Arrangements</strong></th>
<th>groups and local charities to ensure these transformations meet the needs of all patients.</th>
</tr>
</thead>
</table>
| **Other Information** | Our expert members and stakeholders are familiar with the working areas of each of our bids and have been fully consulted and engaged with the bidding process. We are confident we have the vision, expertise and supporting networks to allow us to operate effectively within the new structures, driving our ambitions through at scale and pace.  
  
The bids and work of the two Cancer Alliances in the South West are closely linked. They share a Cancer Network Manger as operational lead, as well as collaborating on a number of projects. Whilst this bid can stand alone we will explore how to extract greater value for money by collaboration between the two South West Cancer Alliances. We will also ensure the improvements and learning is shared across the South West. |
| --- | --- |
Living With and Beyond Cancer

Improving support for people living with and beyond cancer by implementing the Recovery Package

This section covers the strategic direction for the combined programme for Living With and Beyond Cancer, incorporating both the Recovery Package and Stratified Pathways of Care.

Vision

The Peninsula Cancer Alliance vision is for all patients regardless of geographical location, demography or tumour site, to feel that their holistic needs are understood and they have access to support. This will be achieved by implementing the elements of the Recovery Package. Unmet needs identified through the recovery packages that are not met by self-management education will be referred or signposted to appropriate services, whether in hospital, community or third sector settings. Partners across the alliance have agreed a standard of care and will empower all patients to achieve this standard through implementation of this programme.

Dependencies

- The implementation of risk stratified pathways and the ability to support patients to move onto supported self-management, relies upon the successful implementation of the Recovery Package. As such this programme will be run as a single programme in the Alliance with the risk stratified pathways programme. A number of programme resources will be shared with appropriate apportionment of costs having been made to each bid.
- STP projects – successful implementation of the Recovery Package will ensure full alignment with the STP. This relationship has been outlined elsewhere in the bid, but essentially a significant proportion of this work will align other STP projects.
- Cross working over alliance boundaries – the success of the implementation of the Recovery Package will rely on sharing of best practice across and beyond the two alliances in the South West.

See Appendix 3
This is particularly relevant where work and pathways may cross alliance boundaries. The role of the SW Programme Manager will support this cross-facilitation learning.

Why?

Because everyone needs to know that cancer isn’t necessarily an automatic death sentence - some people live for years even with advanced disease.

Because, if you have cancer, there are many small things that you, your friends and family can do beyond just “having the treatment”, that can make a big positive difference to your experience and your wellbeing.

Because, by becoming actively involved you can increase your chances of living as well as possible for as long as possible, so you need to get the right information and support at the right time for you.

Providing a complete recovery package will increase the number of patients being signposted to, referred to, and accessing support services that address any unmet physical, social, and psychological needs

This will improve their quality of life, help them reduce preventable risk factors for recurrence and empower them to self-manage (to an appropriate level); reducing the need for unnecessary follow ups, and/or interventions and improving access for those who need further specialised care.

We aim to develop a workforce which is able to work smarter, optimising our resources with a model that has an appropriate skill mix, to deliver the needs of the Recovery Package. The training, skill mix and expertise of our reconfigured workforce will ensure that all patients are sign-posted to the services they need to support their care plan. These services will be more efficiently utilised across the health and care system.

Ultimately we will work collectively to improve patient experience and outcomes, optimise resource and help the system to adapt to and work effectively with the rising demands on the NHS.

How will this be achieved?

1. Developing the Support Worker resource across the Alliance
2. Improved patient access to Health & Wellbeing support
3. Support for Primary Care to Improve Cancer Care Review
4. Alliance-wide psychology training programme
5. Development of metrics and information systems to drive delivery

1. Developing the Support Worker resource across the Alliance

We currently have a limited number of cancer support workers based in hospitals and communities who are providing 1:1 information, support and assisting the delivery of health and wellbeing events and courses. We will use bid monies to scale up the number of support workers across the Alliance which will enable increased delivery of HNA and care planning in addition to the provision of 1:1 support and delivery of H&WB events across acute and community venues. The Alliance psychological training programme will enable appropriate training to be provided to existing and new support workers.

We will build on local experience of the use of support workers i.e. Bristol, Bath and Weston-Super-Mare and from Improving Cancer Journey Scotland, to increase the capacity and coordination of our support workers across the Alliance geography, basing them across secondary and primary/community care.
Patients would be allocated a support worker who, depending on what is needed/best for the patient, would be able to offer HNAs and care planning, information, signposting and referring to other services. In addition support workers would run and support regular H&WB events, self-management courses, and set up local support groups and peer to peer support. The support worker would work closely with CNS’s and GP practices to offer integrated care and community based holistic support. The support would be essential to deliver stratified follow-up in the area.

2 Improved patient access to Health & Wellbeing support

Full details of this are in the Health & Wellbeing Clinical Outcomes section however outline actions are as follows:

- Develop programme of co-ordinated health & wellbeing events to be delivered in a variety of venues across the Alliance
- Utilise the Cancer Support Worker workforce resource to deliver co-ordinated 1:1 support across acute Trusts and community

3 Support for Primary Care to Improve Cancer Care Review

Part of the Alliance vision is for all patients to feel that their holistic needs are understood. Two of the four key elements of the recovery package address this; The holistic needs assessment and care planning – initially completed by the patient with support from their Cancer specialist team during the acute phase of their specialist treatment -, and the cancer care review performed in primary care by the GP. Cancer patients also access the care planning and long-term condition support that is not disease specific.

Our transformation work proposes to work with all stakeholders to evolve existing resources and ensure patients are able to communicate their needs at a time and to a health care professional of their choosing, in addition to the initial HNA’s performed as part of their specialist cancer treatment pathway, and their initial Cancer Care Review in primary care. This could be by performing a further holistic needs assessment with their Cancer Nurse Specialist, a further Cancer Care review with their GP or practice nurse, by completing a cancer specific element added to their long-term condition care plan with a health coach or a combination of these.

There will be training and support for the primary care team (GPs, practice nurses, support workers) to enhance and improve the cancer care review, together with initiatives within both sectors, to improve communication between primary and secondary care. See also Cancer Care Review page 13

4 Alliance-wide psychology training programme

The Alliance will improve the psychological care of patients by training staff to deliver brief, evidence-based interventions for mild-moderate psychological difficulties. This will ensure all Trusts are equipped on a sustainable basis to meet Level 1 and 2 requirements for psychological support as set out in NICE guidelines and Quality Surveillance frameworks.

There is a nationally accredited and evaluated Advanced Communication Skills training package. There are no longer accredited providers of that ACST package in the Alliance region. Level 2 training is not currently delivered across the Alliance. University Hospitals Bristol is developing a programme and the framework and materials would be available to be shared with this programme. Psychological skills supervision will be available for all practitioners within Alliance providers and through the Steering Group will support the implementation of skills in practice.

Objectives:

- Establish a pool of facilitators across the network accredited to deliver the NCAT Connected model for Advanced Communication Skills (Level 1 requirement)
- Co-design, deliver and evaluate an evidenced based sustainable programme of staff training in Level 2 psychological support skills
- Co-design of standardised online resources for trainers and trainees, including core evaluation data
Production of an implementation guide for localised delivery

5 Development of metrics and information systems to drive delivery

The Alliance will develop a set of metrics that will be recorded real time on patient information systems. This will enable clinical teams to see which patients have received the various elements of the recovery package and their status on risk stratified pathways of care. This will enable team to intervene to delivery elements that are due but have not yet been delivered. This will be a vital tool in driving up the spread of support to all patients.

The Alliance will also be able to use this information to understand the locations and tumours where recovery package implementation need to be more specifically supported and will help us understand the different needs of different patients and tailor our approach to ensure a flexible but universal offer of support.

The Alliance will work with the Somerset Cancer Registry, which is based in our neighbouring Alliance (SWAG), to develop the Registry to enable this level of information to be quickly and consistently collected at patient level. We will also work with providers using Infoflex and other patient information systems to develop consistent approaches.

As the Somerset Cancer Registry is used by about half of all providers in England this will provide benefits much wider that the SWAG Cancer Alliance. The Alliance is already engaged with the national benchmarking and metric work to support the development of a national approach to the use of information to drive improvement in patient support.

LWBC Alliance Ways of Working

We have a history of sharing best practice across the alliance, with strong partnerships involving all CCGs and trusts both within the individual footprints and across the two South West alliances. The South West Cancer Strategic Clinical Network plays a key role in sharing best practice between the alliances, and working to find opportunities to scale learning and programmes up to the regional level.

The Alliance has strong working relationships with wider system partners, who are all actively engaged in the approach being taken for this programme. These partners include Macmillan Cancer Support, the Somerset Cancer Registry, Public Health England (PHE), and FORCE. A current example of this partnership working; the Somerset Cancer Registry and PHE are sharing their expertise in the development and testing of a national dataset for the Recovery Package, ensuring compatibility with all other hospital cancer systems and ultimately informing the commissioning of LWBC services.

Working together as an alliance adds value to the individual healthcare communities through the sharing of learning and resource to raise each community to a standard of LWBC provision that reflects the best practice. The Alliance has examples of sharing and implementing work at this level, through the Living Well With and Beyond Cancer group (established since 2014); which has already begun to map out variation in provision, and agree standards of care, in preparation for implementation.

We hope to utilise and extend the impact of this group further through the formation of a transformation taskforce to deliver the programme. In each healthcare community there already exist teams supporting both the delivery of cancer specific improvements for LWBC as well as broader work for supporting people in the community. The Alliance will support these teams who will be responsible for the coordination and delivery of the projects associated with the programme. These will come together across the Alliance, with the Alliance Clinical Lead and LWBC Chair providing overall leadership for the programme. It is anticipated this grass roots approach will allow fast implementation and enable
supported/coordinated acceleration in the implementation of the Recovery Package.

A stakeholder engagement plan will also be delivered to ensure patients, clinicians and commissioners work together to ensure that there is effective coproduction happening at all levels (operational and strategic).

**Strategic STPs Alignment – Working in Partnership**
The vision and proposal closely aligns with the work of all the STPs in this area. There is a commitment from each STP in their prioritisation of cancer services, as supported by the Five Year Forward View. Delivery of this proposal will be embedded into the STP work, by the flow of funding from the Alliance to the STP who will attribute the funding and resources amongst the services.

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**Peninsula Alliance**

- Provides leadership to:
  - **Peninsula Living Well With and Beyond Cancer Group**
  - **Transformation Task Force**

**STPs**

- Cornwall and the Isles of Scilly
- Devon

**Funding**

**Recommendations**

Coordinates and delivers work plan for LWBC and the implementation of risk stratified pathways
Work Plan
To create system transformation at pace, in order to accelerate progress in 17/18 towards the vision that **all cancer patients** will receive the Recovery Package intervention, the following work plan is proposed. The investment outlined in the financial template, will support the plan below.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Tasks</th>
<th>Time Frame</th>
<th>Cross Cutting Work</th>
</tr>
</thead>
</table>
| Project Set up | - Form transformation task force  
- Agree roles and responsibilities  
- Confirm governance arrangements | October 17          | **Workforce**  
Additional Support workers                                                                 |
| Design     | - Where not alr4ady agreed, design and implement quality standards  
- Share best practice implementation and methodology | October 17 – November 17 | **Training**  
Support workers  
Primary Care  
Psychological Support                                                                 |
| Scope      | - Map current projects and services  
- Gap analysis against provision of all elements of recovery package  
- Priority interventions to support all to get to the best  
- Identify and plan interventions to accelerate existing work | November 17 – January 17 | **Stakeholders**  
Plan to engage and communicate all                                                                 |
| Implement  | - Support sites to implement targeted work against project and programme plan | January 18 – March 19 | **IT**  
Supporting IT projects to enable recovery package, i.e. remote devices, interface with patient systems |
| Evaluation | - Agree evaluation methodology and plan based on design principles  
- Baseline  
- Continuous evaluation to improve system as transformation takes place | October 17 – March 18 |                                                                                  |

Please see appendix 1 for a logic model which displays the full plan and further indicators of activity which will be taking place. Additionally appendix 2 demonstrates how our local projects contribute to the alliance wide plan.
Intervention 2: Recovery Package

Improving support for people living with and beyond cancer by implementing the Recovery Package

See Living With and Beyond Cancer section at the beginning of the bid. This covers the strategic direction for the combined programme for Living With and Beyond Cancer, incorporating both the Recovery Package and Stratified Pathways of Care.

Clinical Outcomes
In achieving the metrics below, it is hoped that positive improvements to outcomes in physical, social and psychological health will improve, as seen on the holistic wheel pictured.

Quantify the increase in patients who receive a Holistic Needs Assessment and Care Plan within 31 days of diagnosis, and

- By the end of Year 1 40% of all patients to be offered an Holistic Needs Assessment and Care Plan within 31 days of diagnosis
- By the end of Year 2 50% of all patients to be offered an Holistic Needs Assessment and Care Plan within 31 days of diagnosis

- This is for all tumours but will be monitored by tumour site. The table below demonstrates this will equate to 80% of Breast, Colorectal and Urological patients
- We will monitor the number of HNAs and Care Plans delivered (as well as offered).
- We will monitor the number offered within 31 days of diagnosis and those offered, but late.
- An HNA and care plan before confirmed diagnosis will count.
- An HNA that generates no issues to be captured in a care plan will count.

According to the National Cancer Patient Experience survey, 2015 approximately 25% of those surveyed, received a Care Plan in the Alliance – all cancer sites. As part of the programme; a more comprehensive baseline picture will be established and collected through the Somerset Cancer Registry and InfoFlex.
When looking at the local data (where available) approximately 36% of all cancer patients across 2015/2016 received an HNA and care plan within 31 days of diagnosis. A proportion of these will be electronic (e-HNAs). These take place across many of the core tumour groups, as well as other key sites including haematology, sarcoma, Teenage and Young Adult, radiotherapy and chemotherapy. In parallel to the work of implementing HNAs, several sites will focus on the implementation of e-HNAs.

Certain sites are actively piloting and rolling out the use of HNAs early on in the pathway (compliant with the 31 day diagnosis standard). The learning from this will be shared across the patch as the use of HNAs is embedded across all cancer pathways.

### Holistic Needs Assessment and Care Plan within 31 days of diagnosis

<table>
<thead>
<tr>
<th>Year</th>
<th>Ambition for All Patients</th>
<th>Implied ambition for subset of Breast, Colorectal and Urological patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>25% 3162</td>
<td>60% 3152</td>
</tr>
<tr>
<td>Year 1</td>
<td>40% 5068</td>
<td>70% 3667</td>
</tr>
<tr>
<td>Year 2</td>
<td>50% 6341</td>
<td>80% 4185</td>
</tr>
</tbody>
</table>

Steps to achievement include: developing the support worker posts, agreeing responsibility through the lead nurses, providing clinical support - particularly through clinical directors for cancer services and embedding into the agenda of Site Specific cancer groups-system support such as Somerset database, accountability and reporting through the LWBC Alliance group with provision of project and administrative support.

Quantify the increase in patients who receive a Holistic Needs Assessment and Care Plan within six weeks of end of acute period of treatment.

- By the end of Year 1 40% of all patients to be offered an Holistic Needs Assessment and Care Plan within six weeks of end of acute period of treatment
- By the end of Year 2 50% of all patients to be offered an Holistic Needs Assessment and Care Plan within six weeks of end of acute period of treatment

- This is for all tumours but will be monitored by tumour site. The table below demonstrates this will equate to 80% of Breast, Colorectal and Urological patients
- We will monitor the number of HNAs and Care Plans delivered (as well as offered).
- We will monitor the number offered within 31 days of diagnosis and those offered, but late.
- An HNA and care plan before confirmed diagnosis will count.
- An HNA that generates no issues to be captured in a care plan will count.

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2 Data collected from North Devon Hospital Trust (Jan15-Dec16), Royal Cornwall Hospitals NHS Trust (Apr 15-Mar 16), Plymouth Hospitals NHS Trust (Jan16-Dec16). Scaled up to cancer incidence by trust on Cancer Waits (Jan 15 – Dec 16)
According to the National Cancer Patient Experience survey, 2015 approximately 25% of those surveyed, received a Care Plan in the Alliance – all cancer sites. As part of the programme; a more comprehensive baseline picture will be established and collected through the Somerset Cancer Registry and InfoFlex.

### Holistic Needs Assessment and Care Plan within six weeks of end of acute period of treatment

<table>
<thead>
<tr>
<th>Year</th>
<th>Ambition for All Patients</th>
<th>Implied ambition for subset of Breast, Colorectal and Urological patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% receiving</td>
<td>Number receiving</td>
</tr>
<tr>
<td>Baseline</td>
<td>25%</td>
<td>3162</td>
</tr>
<tr>
<td>Year 1</td>
<td>40%</td>
<td>5068</td>
</tr>
<tr>
<td>Year 2</td>
<td>50%</td>
<td>6341</td>
</tr>
</tbody>
</table>

Steps to achievement as per previous section

- By the end of Year 1 30% of all patients will have a treatment summary
- By the end of Year 2 50% of all patients will have a treatment summary
  - This is for all tumours but will be monitored by tumour site. The table below demonstrates this will equate to 80% of Breast, Colorectal and Urological patients

Currently only 5% of cancer patients receive a Treatment Summary across the Alliance

This low reported uptake is partially due to missing data, but also demonstrates there is much more work needed to be done in order to increase the implementation of treatment summaries. There are a number of local projects which the Alliance will coordinate and divert funding to accelerate.

GP\s will receive an End-of-Treatment Summary for all their patients and will use the Treatment Summary to inform individual Cancer Care Reviews with their patients.

Patients will use the Treatment Summary to take a more active role in the management of their own health. The Treatment Summary will also be used by other clinicians, particularly in Emergency Departments, for unplanned emergency admissions.

Treatment Summaries will conform as a minimum to the content set out in the National Treatment Summary Template. Hospital systems will be developed to embed agreed treatment summary templates to make completion simple and consistent. The Programme will work with the Somerset Cancer Registry and InfoFlex to make these changes.
Each Network Site Specific group will agree the timing and core content of treatment summaries. We will identify a clinical champion in each trust and work with their clinicians to deliver a change programme.

<table>
<thead>
<tr>
<th>Patients who receive a Treatment Summary</th>
<th>Ambition for All Patients</th>
<th>Implied ambition for subset of Breast, Colorectal and Urological patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>% receiving</td>
<td>Number receiving</td>
</tr>
<tr>
<td>Baseline</td>
<td>5%</td>
<td>632</td>
</tr>
<tr>
<td>Year 1</td>
<td>30%</td>
<td>3801</td>
</tr>
<tr>
<td>Year 2</td>
<td>50%</td>
<td>6341</td>
</tr>
</tbody>
</table>

Steps to achieving, as previously but also include securing a GP lead: we also have a number of Macmillan GPs in Devon and Cornwall supporting the cancer agenda and whose work programmes will reflect supporting the LWBC programme.

Quantify the increase in patients who receive a Cancer Care Review and plans to work with Primary Care to improve compliance with this and communication between primary and secondary care.

Local CCGs archived at least 97% for the Cancer Quality and Outcomes Framework in 2015/16. Therefore no changes in this metric are anticipated.

At the end of active treatment, a number of patients describe it as “like falling off a cliff”. The development of robust pathways between secondary and primary care is vital to ensure this is not the experience of patients following the recovery package and risk stratified pathways of care.

Work is already happening across the Alliances to improve the quality of cancer care reviews (CCR) and Primary Care has been engaged as part of the bid writing process (via Macmillan GP Leads) to draft proposals for improving the quality of cancer care reviews; comprehensive education masterclasses are currently run in Gloucestershire and practices participate in the Primary Care Offer of which cancer is an essential building block. Training for practice nurses in cancer care and CCR has been organised by Macmillan GPs in Bristol, Gloucestershire and Somerset. The Cornwall Macmillan practice nurse adviser has initiated training packages for practice nurses which the Peninsula would adapt for local need; the treatment summary is being reviewed and implemented locally in order to inform GPs and patients as to key elements of the cancer journey, picking up any significant aspects identified in the holistic needs assessments as well as clinical information, common side effects of treatment and re-entry to services should symptoms recur.

The RDE has arranged a local Master-class, and recurring GP events to introduce and maintain the focus on LWBC. To complement this project a wider community event is planned this year (November 16th) for community nurses and allied to health professionals. We prosed to train one clinician (practice nurse or GP) and one social prescribing co-ordinator (community champion) per practice.

Transformation funding will enable the programme will explore building on the current CCR/QOF to create a sustainable consistent approach, adding definition to the current CCR in order to inform future Primary Care commissioning: the bid
would enable continued creation and piloting of a framework for delivery; best practice including quality standards and the supporting of more training packages for GPs and practice nurses. Support workers will also be used and developed to provide the interface between Primary and Secondary care.

We will explore focusing the £425k funding from QoF to those patients who will most benefit from additional support in primary care. This may be both those discharged to supported self-management soon after treatment and those with co-morbidities (especially the frail elderly).

We will also explore running health & wellbeing support events in the community, using community support workers. This would be a mixture of group and 1-1 intervention.

Other steps – see previous section

<table>
<thead>
<tr>
<th>Quantify the increase in patients accessing holistic information and support through a ‘Health and Wellbeing Event’ or similar.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AND</strong> Outline plan to increase access to Health and Wellbeing Events or similar and improve efficiency of delivery by mapping availability and working across sectors within Alliance footprint.</td>
</tr>
</tbody>
</table>
| **Health and Wellbeing Events** Currently patients are invited to a specific event held at their local provider—types of events differ across the Alliance. There are a variety of site specific events being carried out as well as more general events. The frequency of these vary from some being annual (not sufficient) to others being monthly/fortnightly. Certain sites, such as Exeter for Urology, have implemented a Health and Wellbeing event for patients prior to treatment. This change has had a significant impact, with patients reporting high levels of satisfaction with these events. However it has also prevented unnecessary interventions in patients, including admission avoidance as the patients were empowered to challenge non-specialist recommendations. It also demonstrated a reduce amount of calls to the CNS from the pilot group therefore impacting positively on the CNS workload. The RDE generic clinic is seeing increased referrals and attendance with intelligence gather to now allow us to commence outreach.

This proposal considers developing an approach which will increase availability, so that all patients have the opportunity to attend a Health and Wellbeing Event within three months of diagnosis, appropriate to their needs/prognosis.

The Alliance will develop programme of coordinated health and wellbeing events, self-management courses/events available to people affected by cancer who are living in the Alliance. Building on existing events/courses we will have a flexible programme of community and online resources that give people choice to decide what support they need and when and how they access it, it also acknowledges peoples’ needs change over time. Working across the Alliance geography would

**by the end of Year 1 15% of all patients will have access to self-management support through a range of Health & Wellbeing events, classes and self-management courses**

**by the end of Year 2 33% of all patients will have access to self-management support through a range of Health & Wellbeing events, classes and self-management courses**

- This is for all tumours but will be monitored by tumour site. The table below demonstrates this will equate to 60% of Breast, Colorectal and Urological patients
- Currently only 5% of patients attend Health and Wellbeing Events or similar.
mean we could be more efficient, improve access, share best practice, and reduce
gaps in service provision and differences in quality. We want to work with NHS and
voluntary sector organisations to meet the needs of our population. Everybody with
a cancer diagnosis would receive the information on the rolling programme of
activities and we would include this in our evaluation to test and learn. The
programme would be essential to deliver stratified follow-up in the area.

**Coordinated 1:1 support across the Alliance**

Our support workers are based in hospitals and communities to provide 1:1
information, support and deliver the health and wellbeing courses. With sufficient
training, support workers are able to help people with their HNAs and care
planning, offering one to one support and running living well with and beyond
courses. Learning from *Improving Cancer Journey Scotland*, we would like test a
different approach to increasing capacity and coordinating our support workers
across the Alliance geography, basing them across secondary and
primary/community care. Patients would be allocated a support worker who,
depending on what is needed/best for the patient, would be able to offer HNAs and
care planning, information, signposting and referring to other services. In addition
support workers would run and support regular self-management courses, and set
up local support groups and peer to peer support. The support worker would work
closely with CNSs and GP practices to offer integrated care and community based
holistic support. The support would be essential to deliver stratified follow-up in the
area.

**Patients accessing holistic information and support through a ‘Health and
Wellbeing Event’ or similar**

<table>
<thead>
<tr>
<th>Year</th>
<th>% receiving</th>
<th>Number receiving</th>
<th>% receiving</th>
<th>Number receiving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>5%</td>
<td>632</td>
<td>10%</td>
<td>525</td>
</tr>
<tr>
<td>Year 1</td>
<td>15%</td>
<td>1901</td>
<td>30%</td>
<td>1572</td>
</tr>
<tr>
<td>Year 2</td>
<td>33%</td>
<td>4185</td>
<td>60%</td>
<td>3139</td>
</tr>
</tbody>
</table>

Please outline your plan to monitor and measure the outcomes of the interventions.

Would you be willing to evaluate any of the following sub-assertions from pilots
as part of delivery?

1. The impact of healthy lifestyle and physical activity advice (given during HNA and
CCR) on risk of recurrence.

Information systems (Somerset Cancer Registry and Infoflex) will be adapted to
ensure real time monitoring of patients care will be possible. This will show clinical
teams which patients have yet received the relevant parts of the Recovery Package,
at each stage in their pathway. This will enable clinicians to address any shortfalls at
the time. This information will also be used to collect aggregated data on
performance, to monitor progress with the programme and identify patients groups
(by locality or tumour) for which actions is required to implement the Recovery
Package.

The South West Allainces will jointly support the national development of the
Somerset Cancer Registry (in use in over 100 trust in England) and in conjunction
with the Somerset Cancer Registry would like to offer support to the National
Cancer Team in developing metrics for the Recovery Package.
2. The impact of healthy lifestyle and physical activity advice given during HNA and CCR development of other long term conditions.
3. The impact of early identification and treatment of consequences of treatment on reduced prescription costs.
4. The impact of the Recovery Package interventions on an individual’s confidence to self-manage.

It is not expected that any Alliance will collect and evaluate all of this information. We are looking for Alliances to test sub-assertions that have been shown in some pilots, to improve the evidence base and contribute to overall evaluation.

<table>
<thead>
<tr>
<th>In order to assess that the Recovery Package is in place, the following metrics have been agreed:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metrics</strong></td>
</tr>
<tr>
<td><strong>Holistic Needs Assessment</strong></td>
</tr>
<tr>
<td>1. Record date of each HNA</td>
</tr>
<tr>
<td>2. Record date HNA offered but declined</td>
</tr>
<tr>
<td>3. Date of diagnosis to be “Date patient informed of diagnosis” or if not available “Date diagnosis”</td>
</tr>
<tr>
<td>4. Date of end of acute period of treatment to be “Date definitive Treatment +x weeks” (surgery x= 6 weeks, Radiotherapy x= 14 weeks, Chemotherapy x= 12 weeks).</td>
</tr>
<tr>
<td>5. Generally the first HNA to be full review of all HNA tool. Subsequent HNA to be tailored as deemed appropriate by nurse specialist.</td>
</tr>
<tr>
<td>6. Actions at each HNA to be recorded.</td>
</tr>
<tr>
<td>7. Actions to be included with treatment summary as a care plan, for each treatment.</td>
</tr>
<tr>
<td>8. Link to Patient Activation Measures (outlined below) to understand how the patient is involved, understands and owns their care plan.</td>
</tr>
<tr>
<td><strong>Care Plan</strong></td>
</tr>
<tr>
<td><strong>Treatment Summary</strong></td>
</tr>
<tr>
<td>9. Treatment summaries to be in agreed format.</td>
</tr>
<tr>
<td>10. Treatment summary should be written (in place of consultant letter) of all modalities of treatment (e.g. Cancer surgery, chemotherapy, radiotherapy) and at the start of long term ongoing treatment options (eg. endocrine treatment, active monitoring, watch and wait. These should be shared with patient and GP.</td>
</tr>
<tr>
<td>11. Date of risk stratification to be recorded for all patients</td>
</tr>
<tr>
<td>12. Patient Activation Measures and similar monitoring tools will also capture the information for when risk is reduced or increased in future reviews.</td>
</tr>
<tr>
<td>13. At risk stratification an End of Treatment Summary/Continuation of Specialist Care Summary should be written. This should include the current care plan and be shared with the patients and GP.</td>
</tr>
<tr>
<td><strong>Health &amp; Wellbeing Events (HWE) and Support</strong></td>
</tr>
<tr>
<td>1. Date patient given information on range of HWE support to be recorded. % of patients informed will be monitored.</td>
</tr>
<tr>
<td>2. Number of attendees at HWE to be recorded (with equality metrics). A Cancer HWE will be deemed as any such clinic, group or meeting commissioning as a HWE (whether cancer or generic).</td>
</tr>
<tr>
<td>3. Number of sites collect feedback from HWE, this will be collated to help understand the impact to patients and carers to ensure that the events are effective.</td>
</tr>
<tr>
<td>4. NB – patients and carers will be encouraged to attend and use HWE and support at all stages of their pathway (including before treatment and at any time after end of treatment). This means the recording of attendance and matching with invitation will be complex and patients could attend multiple events. Any reporting will not be able to have the same cohort in numerator and denominator in general across the Alliance. Local audit work will continue to understand uptake of HWE by specific cohorts of patients.</td>
</tr>
</tbody>
</table>
### Cancer Care Review

5. Existing QOF mechanisms will be used to assess compliance with this element.
6. Practices will be supported to develop QI initiatives in improving quality of cancer care reviews.

The Alliance will assess the improvement on an individual’s confidence to self-manage, using tools such as the Patient Activation Measure (PAM) where it has been commissioned or MYCAW (measure yourself concerns and wellbeing).

### Patient Experience

Please outline plans to monitor patient experience across all elements of the Recovery Package. Please draw on any relevant projects or initiatives in your footprint.

<table>
<thead>
<tr>
<th>Key indicators of improved patient experience includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- All cancer patients can say “I am ready for my treatment”, “I am supported as a whole person” and “I have some control over my health and wellbeing” and staff, volunteers and carers can say “I am supported to give the support cancer patients/family members need”</td>
</tr>
<tr>
<td>- Patient experience improves due to access to the type of support they need when they want it.</td>
</tr>
<tr>
<td>- Patients feel empowered to manage their condition, improving their quality of life.</td>
</tr>
<tr>
<td>- Patients can say “I can live as well as possible with or beyond my cancer”.</td>
</tr>
</tbody>
</table>

Patient experience will be monitored as part of the continuous evaluation that the Alliance commissions (see evaluation section for further indicators which will make up a consistent framework and metrics agreed at the alliance level). This builds on the existing LWBC project funded by Macmillan in Bristol CCG. Across the Alliance, there are excellent examples of how to measure patient experience and use the data to inform future provision and service design. The alliance partner Penny Brohn UK, has agreed to share the expertise in this area, having recently worked with Nesta and The Health Foundation to evaluate their services.

Our evaluation will be based on the needs and impact on patients, their carers and staff and volunteers, particularly focussing on quality of life and patient experience. Using data that is already collected (through Friends and Family, NCPES, service evaluation questionnaires and ad hoc feedback) and more in depth methodologies (focus groups, interviews and storytelling), we will look at the patients’ experience of individual services they use and more generally, as a cancer patient moving through the system.

Regular feedback will guide our improvement work. The evaluation will also set up more sustainable local data collections, embedded in our systems, so that the value will remain after the funding. We will work with staff and patients in developing our tools to ensure the collection is not too burdensome and works within the current IT systems and interactions with patients.

Alliance providers have previous experience of evaluating patient experience in relation to Health and Wellbeing. A selection of patient quotes are included below which demonstrates that the evaluation took place and that positive feedback was obtained from participants.
**Feedback**

**Breast**
“Varied and helpful. The presence of an ex-cancer patient and cancer nurse makes it interesting and helpful.”

“The course gave me reflection time to consider my life style and support to make those small changes that can really reduce anxiety and stress.”

“It has really helped me it’s a fantastic resource and should be available to everyone across the UK”

“Before I came onto this course I was at a point I didn’t know what to do to help myself/stress and anger. This course has really helped me move on.”

**Prostate**
“A general feeling of enlightenment shines through. It was good to talk to others in a happy context.”

“I don’t usually warm to this kind of experience - sharing discussion. But in this case it was extremely productive, at least partly due to the skills of the presenters”

**Bowel**
“Getting to know a small group has been great - we intend to keep in touch. It’s supportive to have new friends on the same journey.”

**Skin**
“Thanks for helping me ‘turn the corner’ and for providing tools to help me when I slip back into negativity.”

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**Quality and Safety**

Please outline plans to assure the quality of delivery of the four components of the Recovery Package.

Quality will be assured by

1. Use of NCPES
2. Evaluation of project to include target patient engagement work (survey and face to face) and other auditable quality measures such as complaints
3. Peer review by all health care professionals across the Alliance delivering holistic needs assessments and cancer care reviews led by CNSs. Each CNS will have their own practice peer reviewed and will peer review others. This will support individual growth but also enable benchmarks for quality in the elements of the Recovery Package to be agreed.
4. This will be collated to across the Alliance to define standards, training and competency framework for staff delivering the Recovery Package.
5. Psychological Support will be provided to ensure clinical staff have the right training to support psychological needs and the appropriate supervision.
6. A process for developing and assuring the quality of all patient information developed for the Recovery Package across the Alliance. Where possible the Alliance will use existing patient resources both from within and external to the Alliance, to minimise additional work.
7. Where possible we will move to an all IT infrastructure so that templates can be more easily accessed and monitored.
8. Robust delivery of actions to resolve issues identified.

**Sustainability**

Please demonstrate commitments to fund service after transformation funding is withdrawn.

A key focus of the evaluation of the Recovery Package and Risk Stratified Follow-up is to assess the cost-benefit to the system of these programmes of work. Work is needed to understand further the enablers of realising cashable savings that are released from the system. Therefore a key component for the Programme will be the development of an STP led project to develop and agree a sustainable commissioning and delivery model for the Recovery Package that both ensure cost effectiveness but sustains the improvements achieved within this Programme. This work will be designed with key commissioning decision makers, to ensure the outputs are usable in their local context. This will be supported by Alliance funded work to review; diagnostics capacity and demand, cost effectiveness of cancer services and robust activity projections for cancer services. The work will review; cost of sustainable delivery of the recovery package, saving from reduced follow up and reduced nurse specialist contact from self-managing patients, reduction in other health care costs from supporting self-management and synergies with our local healthcare services and development in the STP.

The investment in IT development and training will enable increased productivity to be achieved. It is also anticipated that substantial savings are likely to be made through reduced follow-up and utilising resources in a most cost effective way (including taking an Alliance wide approach to resource utilisation where appropriate) and these will become apparent through evaluation of these programmes of work. National tools such as the NESTA “Realising the value: economic modelling tool” will be considered as part of the evaluation design. Depending on the scale of the savings it is hoped that the programmes can become self-sustaining and on this basis CCGs would be willing to commit to the long term future of the project. If it is evident throughout the project that the savings released are not sufficient further decisions will be required on the long term future of these projects of work. This could include tailoring the costs of the programme to better match the savings released.

The Alliance has designed the bids for the Recovery Package and Risk Stratification with cost effectiveness and efficiency in mind. This includes the introduction of band 4 support workers to release clinical staff to transform the way that support is delivered, improving access though offering events and courses across the Alliance, and sharing best practice (there are a number of centres who already offer elements of the Recovery Package and Risk Stratified Follow-up). As such the bids are designed with Return on Investment in mind, acknowledging that the scale of savings will become apparent throughout the process of evaluating these programmes.

We will continue to work with partners such as Macmillan and local charities to ensure that any plans for resources are aligned to our learning, agreement that any business cases are reflective of learning and on-going need. We will also ensure that any existing resource is optimised and continues to support this agenda e.g. the Macmillan GP posts.
Please populate the financial template for **revenue costs** and **capital costs**.

<table>
<thead>
<tr>
<th>Cost</th>
<th>Year1</th>
<th>Year2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-recurrent Staff</td>
<td>764,223</td>
<td>764,223</td>
</tr>
<tr>
<td>Band 4 support works, nurse specialist development posts, AHP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychology Training &amp; support</td>
<td>32,535</td>
<td>60,945</td>
</tr>
<tr>
<td>Health and Wellbeing Support</td>
<td>90,725</td>
<td>90,725</td>
</tr>
<tr>
<td>Includes both course for large number of patients and more targeted support for those with greatest need</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support to primary care</td>
<td>99,152</td>
<td>99,152</td>
</tr>
<tr>
<td>Inc improvements to Cancer Care Review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Review and Standards Development</td>
<td>19,830</td>
<td>19,830</td>
</tr>
<tr>
<td>Clinical Leads and Champions</td>
<td>68,832</td>
<td>68,832</td>
</tr>
<tr>
<td>Programme Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jointly with Risk Stratified Pathways of Care</td>
<td>95,969</td>
<td>95,969</td>
</tr>
<tr>
<td>Evaluation</td>
<td>73,718</td>
<td>73,718</td>
</tr>
<tr>
<td>Inc Commissioning Model &amp; information Analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information System Development</td>
<td>72,469</td>
<td>-</td>
</tr>
<tr>
<td>Communications</td>
<td>15,000</td>
<td>15,000</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>1,332,452</td>
<td>1,288,393</td>
</tr>
<tr>
<td>Remote Monitoring Software</td>
<td>250,000</td>
<td></td>
</tr>
<tr>
<td>Hand-held Devices</td>
<td>19,830</td>
<td></td>
</tr>
<tr>
<td><strong>Total Capital</strong></td>
<td>269,830</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,602,283</td>
<td>1,288,393</td>
</tr>
</tbody>
</table>

**Financial Benefits**

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2018/19</th>
<th>Recurrent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Follow Ups @ £87</strong></td>
<td>319</td>
<td>1595</td>
<td>3191</td>
</tr>
<tr>
<td><strong>Savings</strong></td>
<td>6,947</td>
<td>277,871</td>
<td>277,871</td>
</tr>
<tr>
<td><strong>% recurrent savings realised</strong></td>
<td>10%</td>
<td>50%</td>
<td>100%</td>
</tr>
</tbody>
</table>

These savings will be shared between Recovery Package and Risk Stratified Pathways bids. This is due to the difficulty in attributing one set of savings to each element. The savings will be monitored as part of the evaluation which will take place across the Recovery Package and Risk Stratified Pathways section of the bids, in order to understand what impact is being seen. Greater confidence will be provided in these figures as the project goes on. If the above is seen, this will support the argument for sustainability of the elements of the Recovery Package and Living Well With and Beyond Cancer. However it must be noted that it is anticipated that these savings are non-cashable, as the released capacity will be used elsewhere in the pathway (i.e. time used to fill out HNAs etc.).

See Appendix 7 for more detail
The vision and proposal closely aligns with the work of all the STPs in this area. There is a commitment from each STP in their prioritisation of cancer services, as supported by the Five Year Forward View. Delivery of this proposal will be embedded into the STP work, by the flow of funding from the Alliance to the STP who will attribute the funding and resources amongst the services.

### Risks

#### Competing priorities
- Competing priorities within the wider health system, as well as competing priorities with cancer – progressing objectives relating to LWWBC may not be seen as important compared to the need to deliver against the key national standards. Pressing operational needs may interfere, derailing implementation.
- This bid may not be able to demonstrate explicit alignment with STP plans and budgets due to the high level nature of the information contained within the STP published plans.

#### Lack of capacity
- Lack of capacity within commissioning to focus on this agenda.
- Developing a service specification or commissioning Recovery Packages for each tumour site is complex and time consuming.
- There is a risk that the right clinical staff cannot be recruited to the transformation task force or for on the ground delivery of the Recovery Package. We will mitigate this by the flexibility in which we approach the variety of staff and backgrounds that can appropriately support the Recovery Package.

#### System constraints
- This proposal requires the Alliance to work closely together particularly in delivering training and Health and Wellbeing events. There is a risk that partners will not work together in order to ensure coordination of the programme is achieved. However, the Alliance has a long history of sharing best practice across the geography and all partners are intending to build on existing relationships to ensure this is a success.
- Lack of clarity around tariff and funding streams.
- The level of internal change within acute trusts needed to deliver services.
**Risks**

differently against a background of increased demand (including the capacity needed for workforce development and training).

**Finance**
- The aspirations within this bid may not be met, either at all or within the expected timeframe, if the eventual funding award is reduced compared to the requested amount.

**Mitigation:**
- Strong positive ethos for Living Well With and Beyond Cancer in the system, who will champion this across the alliance and their respective STPs. The South West Strategic Clinical Network will support conversations both regionally and nationally surrounding operational pressures as necessary.
- The Cancer Alliance Board includes representation from each STP. There is very good engagement between STP stakeholders and the Cancer Alliance/Clinical Network and we have received confirmation from all STPs that the bid is in alignment with their aspirations and, for some, provides the detail they are looking for to expand their own plans. Executive leads of STPs will be involved in the Cancer Alliance Board and its decisions on work and budget prioritisation.
- Strategic support from NHS England and the Cancer Alliance.
- Building excellent relationships with provider colleagues.
- Promoting strong clinical leadership and change management in both primary and secondary care
- Inclusion of cancer as a long term condition within the wider spectrum of healthcare.
- The Cancer Alliance Board will be responsible for prioritising the work and the allocation of capital and revenue funding to each STP. The Board will make its judgement based on the most impact that can be made in each STP with the money available.
- Recognition that implementation of the Recovery Package will reduce follow ups and improve throughput. This will release capacity to support achievement of the Cancer Waiting Times targets.
- Prioritisation through the National Cancer Strategy.

**Risk Management**
The Alliance will use these bids and the Alliance funding to create a programme management team. The Alliance has a Living With and Beyond Cancer Group which will hold the risk register for the programme and using the expertise in the group mitigate and deal with risk as they arise.

Risks that cannot be resolved in this way will be escalated to the Cancer Alliance Board or the STPs (depending on the risk)

There is a risk that each alliance will split in approach to implementation of the South West vision (same for Peninsula and SWAG). This will have a negative
### Risks

<table>
<thead>
<tr>
<th>Impact</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact on providers whose patient population span both alliances. The role of the South West Cancer Network manager and the clinical leads will be instrumental in engaging partners to work consistently towards the vision where appropriate.</td>
<td></td>
</tr>
</tbody>
</table>

- **Please describe any relationship risk in your proposal and local mitigations to reduce them.**
  - As mentioned above, this proposal will test the relationships between Alliance member organisations however all members are committed to this proposal and will build on existing relationships.
  - Cancer Care Reviews may be seen by primary care colleagues to be a shift in workload from secondary to primary care at time when primary care is under significant pressure. However this proposal allows for additional support in the community, and will support patients to be better at self-managing, thus reducing demands on primary care.

- **Please describe any risk posed by the targeting of support in your proposal and local mitigations to reduce them.**
  - The Cancer Alliance intends to ensure that all tumour site areas benefit from this proposal and will develop appropriate metrics to ensure that this is the case. We will also address other known health inequalities in the way the support is provided by working with STPs. Each STP has an understanding of variation in their area and the Alliance will work with the STP to ensure this is a consideration in the programme.
  - The resources in each part of the Alliance do vary, in particular the support from Macmillan. This will be taken into account in how the support is targeted. Resources will be targeted at areas that have the lowest metrics – but care will be taken not to disadvantage those localities where the providers, CCG and other agencies and funders have made previous investments in these services.
  - It will be a key feature of targeted support that each area has to support roll out elsewhere. The use of gap analysis with constant impact evaluation will ensure that the best use of targeted input is being made.
  - The Transformation funding will be allocated to STPs by the Alliance to ensure the programme is delivered jointly with the overall work of the STP and to ensure local executive responsibility for the delivery of the outcomes.

- **Please describe any risk posed by lack of links with other strategic plans and local mitigations to reduce them.**
  - Delivers part of the NHS Operational Planning and Contracting Guidance -2017-2019 and so is consistent with all local plans
  - Each STP will carry on having local STP Cancer Working Groups who will continue to oversee all local strategic plans. This will feed into the STP governance structure for additional assurance. Furthermore, the Alliance position will be coordinated by the Alliance.
  - The Transformation funding will be allocated to STPs by the Alliance to ensure the programme is delivered jointly with the overall work of the STP and to ensure local executive responsibility for the delivery of the outcomes.

### Evaluation and Monitoring

<table>
<thead>
<tr>
<th>Monitor and evaluate progress</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The evaluation will reflect the guiding principles as set out in the evaluation strategy for the new models of care from NHS England[1] with a formative element to support ongoing learning and implementation of the service. During</td>
<td></td>
</tr>
</tbody>
</table>

2017/18 we will be conducting a baseline exercise which will include a review of the current logic model with our stakeholders to tailor to our local context and further inform and develop our ongoing monitoring and evaluation plans. The metrics set out above (monitoring outcomes section) will be integral to our evaluation. Local cancer systems will be developed to enable both patient level, real time assessment of delivery and aggregated performance.

The Living Well With and Beyond Cancer programme in Bristol is commissioning an evaluation, funded by Macmillan, to:

- To explore how the Living Well With and Beyond Cancer programme is delivering against its goal and outcomes in the short, medium and long term.
- To understand the current model of service provision across the Living Well With and Beyond Cancer Programme (e.g. support workers in hospitals and community settings) and inform the development of a commissioned model for the future.
- To inform improvements to the programme through interim reports and feedback
- To evaluate what works for whom and in what circumstances in the Bristol Living Well With and Beyond Cancer Programme; this must include what influences senior leaders to drive change under the Living Well With and Beyond Cancer agenda.
- To assess the cost-benefit of the Living Well With and Beyond Cancer Programme, to include stratified follow up and provision of holistic and self-management support.

If successful, we would like to scale up this evaluation to cover the Transformation Fund projects. The evaluation will build on existing data and project level monitoring and evaluation reports. For instance One Gloucestershire’s Macmillan Next Steps Programme will be evaluating the effects of multidisciplinary cancer rehabilitation and draw out evidence and lessons learned on what works, for whom, why and in what circumstances. This will not only inform the local case for change but will inform the alliance level evaluation as well as building the evidence base for cancer LWBC services.

It will be continuous with feedback being provided throughout the lifetime of the project to ensure adjustments can be made to design and delivery as required.

We do not want to be prescriptive in our requirements or the approach to the evaluation. However, we would like the evaluation to follow the following principles:

- Based on the needs and impact on people effected by cancer, their carers and staff and volunteers supporting them, particularly focussing on quality of life and patient experience
- Based on quality improvement methodology; the programme is not a static set of projects but needs to reflect the ever changing reality of peoples’ lives and the environment they live in
- We need to make an effort to hear the voices of seldom heard groups to plan and deliver services that better meet their needs

Be collaborative; there are lots of people involved in this programme of work and the evaluation needs to be something we can all be proud of
### Intervention 3: Stratified Follow-Up Pathways

Improving support for people living with and beyond cancer by implementing stratified follow-up pathways

See Living With and Beyond Cancer section at the beginning of the bid. This covers the strategic direction for the combined programme for Living With and Beyond Cancer, incorporating both the Recovery Package and Stratified Pathways of Care.

### Clinical Outcomes

In following a risk stratified pathway, it enables patients to receive the appropriate care to support their needs post treatment as they head towards self-management. Access to the recovery package, support by remote monitoring will help the effective and early detection of recurrence.

It is recognised that most baseline figures in this total section have been roughly estimated (due to timescales in asking for data). As part of the programme; a more comprehensive baseline picture will be established and collected through the Somerset Cancer Registry.

The Alliance has a number of risk stratified pathways partially in place, with a few complete with varying progress across the Alliance.

The Alliance will introduce Risk Stratified Pathways for breast, colorectal and prostate cancer plus 4 other tumour sites at each provider. An agreed pathway is also being developed for haematology.

### Patients on a Risk Stratified Pathway

<table>
<thead>
<tr>
<th>Year</th>
<th>% receiving</th>
<th>Number receiving</th>
<th>% receiving</th>
<th>Number receiving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>5%</td>
<td>632</td>
<td>10%</td>
<td>525</td>
</tr>
<tr>
<td>Year 1</td>
<td>50%</td>
<td>6335</td>
<td>60%</td>
<td>3143</td>
</tr>
<tr>
<td>Year 2</td>
<td>80%</td>
<td>10146</td>
<td>100%</td>
<td>5231</td>
</tr>
</tbody>
</table>

Please provide the baseline for stratified follow-up pathways across the Cancer Alliance (see specific metrics in assessment framework).

See Appendix 6 for patient numbers and growth projections.

- **By the end of Year 1 25% of new patients will be on a supported self-management pathway**
- **By the end of Year 2 50% of new patients will be on a supported self-management pathway**
  - This is for all tumours but will be monitored by tumour site. The table below demonstrates this will equate to x% of Breast, Colorectal and Urological patients
  - Currently only x% of patients attend Health and Wellbeing Events or similar.

Primary focus will be for Breast, Colorectal and Prostate Cancer plus 4 other tumour sites at each provider. Work done on the Urology pathway at RD&E will be shared across the...
alliance – evidence is being collected which is demonstrating the approximate number of follow ups being saved, and that patient satisfaction associated with the patient following a support self-management pathway.

We aim for these sites,
- 80% of post-care follow-up risk-stratified documented and understood by patients.
- 80% of patients are aware of self-management support programmes and patient information available to them and how to access this.
- 100% of patients are aware of how to re-enter the system.

**Patients on a supported self-management pathway**

<table>
<thead>
<tr>
<th>Year</th>
<th>Ambition for All Patients</th>
<th>Implied ambition for subset of Breast, Colorectal and Urological patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% receiving</td>
<td>Number receiving</td>
</tr>
<tr>
<td>Baseline</td>
<td>4%</td>
<td>506</td>
</tr>
<tr>
<td>Year 1</td>
<td>25%</td>
<td>3168</td>
</tr>
<tr>
<td>Year 2</td>
<td>50%</td>
<td>6341</td>
</tr>
</tbody>
</table>

See Appendix 6 for patient numbers and growth projections

There is no baseline information on this metric. Available data does not allow easy identification of patients on self-management pathways. As part of the programme we will look to collect metrics around the number of patients admitted through a re-entry pathway for suspected recurrence.

Our ambition is that 100% of patients will be supported to access the cancer team if they have signs or symptoms of concern. This includes those still on professional led follow up, as otherwise patients may be inclined to delay reporting issues until their next scheduled appointment.

We will make the signs and symptoms of concern clear for each patient and their GP and make sure they are aware of the method for re-entry. All patients will be aware of how to re-enter the system. This check should form part of a quality cancer care review.

The number of patients that will need this re-entry will vary by tumour, stage, performance status and the treatments they have received, as well as more complex psycho-social factors. The use of this re-entry method will all more effectively utilised by the quality of the support provided to people living with and beyond cancer – as evidence shows that such support will reduces recurrence of cancer.

We will collect information on these issues as part of the programme, building it into our data collection systems. By 2018/19 we will be able to:
- Identify the proportion of self-management patients on a re-entry pathway.
- Identify the number of patients on a self-management pathway re-accessing the service with a recurrence
- Identify the number of patients contacting a named contact line.

In addition, alongside Macmillan, we will continue to support primary care education for GPs and Practice Nurses to enable the completion of quality Cancer Care Reviews, and
The Alliance is interested in participating in a pilot project to measure long-term quality of life of people living with and beyond cancer.

**Patient Experience**

Patient experience and satisfaction will be monitored for risk stratification jointly with the Recovery Package.

In addition we will monitor specific National Cancer Patient Experience Survey questions monitored to understand patient satisfaction.

Patient experience will be monitored as part of the continuous evaluation that the Alliance commissions for the recovery package and risk stratified pathways intervention. This builds on the existing LWBC project funded by Macmillan in Bristol CCG. Across the Alliance, there are excellent examples of how to measure patient experience and use the data to inform future provision and service design. The alliance partner Penny Brohn, has agreed to share the expertise in this area, having recently worked with Nesta and The Health Foundation to evaluate their services.

Our evaluation will be based on the needs and impact on patients, their carers and staff and volunteers, particularly focussing on quality of life and patient experience. Using data that is already collected (through Friends and Family, NCPES, service evaluation questionnaires and ad hoc feedback) and more in depth methodologies (focus groups, interviews and storytelling), we will look at the patients’ experience of individual services they use and more generally, as a cancer patient moving through the system.
Regular feedback will guide our improvement work. The evaluation will also set up more sustainable local data collections, embedded in our systems, so that the value will remain after the funding. We will work with staff and patients in developing our tools to ensure the collection is not too burdensome and works within the current IT systems and interactions with patients.

Specifically with regards to monitoring the NCEPS for patient satisfaction, the following baseline has been collected:

**Baseline [2015]**
20 Did hospital staff give you information about support or self-help groups for people with cancer?
21 Did hospital staff discuss with you or give you information about the impact cancer could have on your day to day activities (for example, your work life or education)?
22 Did hospital staff give you information about how to get financial help or any benefits you might be entitled to

<table>
<thead>
<tr>
<th>Trust</th>
<th>20</th>
<th>21</th>
<th>22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Devon Healthcare NHST</td>
<td>84%</td>
<td>83%</td>
<td>57%</td>
</tr>
<tr>
<td>Plymouth Hospitals NHS</td>
<td>91%</td>
<td>80%</td>
<td>53%</td>
</tr>
<tr>
<td>Royal Cornwall Hospitals NHST</td>
<td>81%</td>
<td>80%</td>
<td>59%</td>
</tr>
<tr>
<td>Royal Devon and Exeter NHSFT</td>
<td>92%</td>
<td>86%</td>
<td>61%</td>
</tr>
<tr>
<td>Torbay and South Devon NHSFT</td>
<td>93%</td>
<td>87%</td>
<td>70%</td>
</tr>
<tr>
<td>England Mean</td>
<td>83%</td>
<td>81%</td>
<td>55%</td>
</tr>
<tr>
<td>England Upper Quartile</td>
<td>88%</td>
<td>85%</td>
<td>63%</td>
</tr>
</tbody>
</table>

We aim to achieve England Upper Quartile performance in these 3 questions by 2017/18 and 2018/19.

Please outline plans to monitor waiting times for surveillance tests (e.g. mammogram) and any expected change in waiting times.

We are aware of the risks to surveillance waiting times, given the potential for additional diagnostic activity presented by NICE guidelines, earlier diagnosis and more robust follow-up. Providers and commissioners are already required to monitor surveillance waiting times, and in some areas for example Endoscopy there is external quality assurance of the processes in place to do this. In addition to the requirements on Providers and commissioners, the Alliance will monitor surveillance waiting times across the geography and will develop the appropriate mechanisms for doing this.

The Cancer network has a strong history of providing data via its local groups and continues to do so at the Cancer Alliance Board. This will include aggregation of available data on remote surveillance.

Whilst the risk has been outlined above, it is hoped stability or improvement will be seen across waiting times for surveillance tests due to the increased focus from project planners via the transformation programme.

Quality/safety

<table>
<thead>
<tr>
<th>Please provide evidence of the remote</th>
<th>Across the Alliance, best practice indicates the following is taking place as part of the agreed pathway.</th>
</tr>
</thead>
</table>
surveillance systems and re-entry pathways that are in place. If only in place in some areas or not at all, please outline plans to ensure quality remote surveillance system/s and re-entry pathways are in place before patients moved to new pathways.

Please also outline plans to monitor rates of detection of recurrence and survival following recurrence.

There are risks to self-management, namely:
- Patients getting lost to follow up
- Patients not presenting, including for surveillance tests
- Patients feeling isolated and not supported to recognise signs of recurrence.

A clear point of contact will be a key requirement of the Treatment Summary and Care Plan – these will be shared with the patient. Contacts will be recorded and monitored through the Cancer Registry, enabling records of patients who use the re-entry pathway to be clearly flagged and tracked. Where there is no attendance at Health and Wellbeing events/clinics the team will make contact to encourage attendance / understand reasons for reticence.

**Sustainability**

Please evidence commitment to fund service after transformation funding is withdrawn.

A key focus of the evaluation of the Recovery Package and Risk Stratified Follow-up is to assess the cost-benefit to the system of these programmes of work. Work is needed to understand further the enablers of realising cashable savings that are released from the system. However it is more likely that nominal savings are only to be achieved at this point. The Recovery Package and Risk Stratified Follow-up bids have not demonstrated Return on Investment because the Alliance id not currently aware of robust evidence to release the required proportion of savings.

For this reason commissioners are not yet in the position to decide whether recurring investment is appropriate. However it is anticipated that substantial savings are likely to be made through reduced follow-up and utilising resources in a most cost effective way (including taking an Alliance wide approach to resource utilisation where appropriate) and these will become apparent through evaluation of these programmes of work. National
tools such as the NESTA “Realising the value: economic modelling tool” will be considered as part of the evaluation design. Depending on the scale of the savings it is hoped that the programmes can become self-sustaining and on this basis CCGs would be willing to commit to the long term future of the project. If it is evident throughout the project that the savings released are not sufficient further decisions will be required on the long term future of these projects of work, this could include tailoring the costs of the programme to better match the savings released.

The Alliance has designed the bids for the Recovery Package and Risk Stratification with cost effectiveness and efficiency in mind. This includes the introduction of band 4 support workers to release clinical staff to transform the way that support is delivered, improving access though offering events and courses across the Alliance, and sharing best practice (there are a number of centres who already offer elements of the Recovery Package and Risk Stratified Follow-up). As such the bids are designed with Return on Investment in mind, acknowledging that the scale of savings will become apparent throughout the process of evaluating these programmes. Evidently if the Alliance is made aware of evidence for savings then these can be included and the current Return on Investment revised.

| How many outpatient follow-up appointments are allocated to patients on current follow-up pathways for the selected cancer types? How is this expected to change? Please outline plans to monitor changes and redistribute capacity to address patient needs. | Based on modelling done in Gloucestershire we expect a reduction 4254 follow ups. This assumes 1.5 the amount modelled for Breast, Colorectal and Prostate. As part of the design of the evaluation, we will work to identify the most appropriate way of tracking cancer outpatient appointments and their anticipated reduction. This could include using the outpatient minimum dataset to code outpatient appointments. In relation to the redistribution of capacity, we anticipate that capacity will be redistributed in a number of ways including time released for first outpatient thereby allowing shorter waiting times and time to deliver the other elements of the Recovery Package including treatment summaries and HNAs. As part of the evaluation, metrics will be designed to track and manage the ways in which capacity is redistributed. The interventions proposed in the Recovery Package and Risk Stratified Follow-up proposals may reduce other health risks if successful – eg Health and Wellbeing events will be aimed at maintaining health generally not merely in respect of cancer. The evaluation will consider how longer term markers of health can be measured. All the categorised benefits / outcomes are listed in the recovery package portion of the bid (especially regarding the financial case). |
Resources
Please use the scoring guidance to assess the level of detail required to enable us to score both the value and confidence of each outcome.

Please populate the financial template for **revenue and capital costs**.

<table>
<thead>
<tr>
<th></th>
<th>Year1</th>
<th>Year2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-recurrent Staff</td>
<td>175,882</td>
<td>175,882</td>
</tr>
<tr>
<td>Band 4 support workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme Management</td>
<td>31,990</td>
<td>31,990</td>
</tr>
<tr>
<td>Evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inc Commissioning Model &amp; information Analysis</td>
<td>57,194</td>
<td>57,194</td>
</tr>
<tr>
<td>Communications</td>
<td>5,000</td>
<td>5,000</td>
</tr>
<tr>
<td>Information System Development</td>
<td>42,634</td>
<td>42,634</td>
</tr>
<tr>
<td><strong>Total revenue</strong></td>
<td>312,699</td>
<td>312,699</td>
</tr>
<tr>
<td>Capital for remote monitoring</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>352,699</td>
<td>312,699</td>
</tr>
</tbody>
</table>

Please populate the financial template costs for **savings**.

Financial Benefits
Please see Recovery Package section, as financial benefits are calculated for the whole Living with And Beyond Cancer Programme as a whole.

Please describe any non-financial resources required to ensure the effective management of your programme and/or which will impact on your ability to deliver the outcomes.

Please describe any additional funding required from NHS England or elsewhere, please set out how much is required and what it is for.

Strategic Consideration
Please describe how your proposal aligns with the STP(s) in your area.

This bid supports the requirements of NHS Operational Planning and Contracting Guidance 2017-2019, specifically
- Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types (p8 & Annex 7)
- ...
- Ensure all patients have access to a clinical nurse specialist or other key worker (Annex 7)
### Strategic consideration

- Local data collection of risk stratified pathways of care and exploring how data may be collected nationally (Annex 7)

The vision and delivery of this programme is closely aligned with the STPs in this area. There is a commitment for each STP in prioritisation of cancer services as supported by the Five Year Forward View. Delivery of this proposal will be embedded into the STP work, by the flow of funding from the Alliance to the STP who will attribute the funding and resources amongst the services. Appendix two also summarises the position of each STP with regards to delivery of their cancer services and aligned projects which will impact patients with cancer.

### Risks

#### Competing Priorities

- Competing priorities within the health system; STPs have a number of competing priorities only one of which is cancer.
- Competing priorities within cancer; progressing objective relating to Risk Stratification are not seen as important compared to delivery of treatment interventions and meeting the NHS Constitutional targets.

#### Lack of Capacity

- Lack of capacity within commissioning to focus on this agenda
- Lack of coding and reimbursement policies that adequately reflect the delivery of LWBC specific services.

#### System constraints

- Lack of clarity around tariff and funding streams
- The level of internal change within acute trusts needed to deliver services differently against a background of increased demand (including the capacity needed for workforce development and training)
- Infrastructure and IT to support interoperability and remote monitoring
- Those living with Cancer have several co-morbidities and receive care from multiple providers. There is significant need to understand and coordinate their care.
- Lack of integration of care plans and Treatment Summaries into electronic health records, to aid with risk stratification

#### Finance

- The aspirations within this bid may not be met, either at all or within the expected timeframe, if the eventual funding award is reduced compared to the requested amount.
- This bid may not be able to demonstrate explicit alignment with STP plans and budgets due to the high level nature of the
Risks

- Information contained within the STP published plans.

Mitigation
- Strategic support from NHS England and the Cancer Alliance.
- Building excellent relationships with provider colleagues.
- Promoting strong clinical leadership and change management in both primary and secondary care.
- Inclusion of cancer as a long-term condition within the wider spectrum of healthcare.
- The Cancer Alliance Board will be responsible for prioritising the work and the allocation of capital and revenue funding to each STP. The Board will make its judgement based on the most impact that can be made in each STP with the money available.
- The Cancer Alliance Board includes representation from each STP. There is very good engagement between STP stakeholders and the Cancer Alliance/Clinical Network and we have received confirmation from all STPs that the bid is in alignment with their aspirations and, for some, provides the detail they are looking for to expand their own plans. Executive leads of STPs will be involved in the Cancer Alliance Board and its decisions on work and budget prioritisation.
- Prioritisation through the National Cancer Strategy.
- Development of an interoperable application to expedite the process of treatment planning and care plan summaries is an important goal.

Risk Management
The Alliance will use these bids and the Alliance funding to create a programme management team. The Alliance has a Living With and Beyond Cancer Group which will hold the risk register for the programme and using the expertise in the group mitigate and deal with risk as they arise.

Risks that cannot be resolved in this way will be escalated to the Cancer Alliance Board or the STPs (depending on the risk)

There is a risk that each alliance will split in approach to implementation of the South West vision (same for Peninsula and SWAG). This will have a negative impact on providers whose patient population span both alliances. The role of the South West Cancer Network manager and the clinical leads will be instrumental in engaging partners to work consistently towards the vision where appropriate.

Please describe any relationship risk in your proposal and local mitigations to reduce them.

This proposal will test the relationships between alliance member organisations as the Alliance seeks to raise everyone to the best across the footprint in elements of the recovery package and enabling risk stratified pathways. Resources will be targeted appropriate (mentioned below). However all members are committed to this proposal and will utilise this to build on existing relationships.
### Risks

Please describe any risk posed by the targeting of support in your proposal and local mitigations to reduce them.

The Alliance intends to ensure that all tumour site areas benefit from this proposal and will develop appropriate metrics to ensure that this is the case. We will also address other known health inequalities in the way the support is provided by working with STPs. Each STP has an understanding of variation in their area and the Alliance will work with the STP to ensure this is a consideration in the programme.

The resources in each part of the Alliance do vary, in particular the support from Macmillan. This will be taken into account in how the support is targeted. Resources will be targeted at areas that have the lowest metrics – but care will be taken not to disadvantage those localities where the providers, CCG and other agencies and funders have made previous investments in these services.

It will be a key feature of targeted support that each area has to support roll out elsewhere. The use of gap analysis with constant impact evaluation will ensure that the best use of targeted input is being made.

Please describe any risk posed by lack of links with other strategic plans and local mitigations to reduce them.

Delivers part of the NHS Operational Planning and Contracting Guidance - 2017-2019 and so is consistent with all local plans

Each STP will carry on having local STP Cancer Working Groups who will continue to oversee all local strategic plans. This will feed into the STP governance structure for additional assurance. Furthermore, the Alliance position will be co-ordinated by the Alliance.

The Transformation funding will be allocated to STPs by the Alliance to ensure the programme is delivered jointly with the overall work of the STP and to ensure local executive responsibility for the delivery of the outcomes.

---

### Evaluation and Monitoring

Please outline how you propose to monitor and evaluate progress during the lifetime of the programme. Please also outline how you will build on and share learning across the footprint and with the national cancer programme.

The Living Well With and Beyond Cancer Programme will be running an evaluation to span across the elements of the recovery package and risk stratified follow up pathways.

The evaluation will reflect the guiding principles as set out in the evaluation strategy for the new models of care from NHS England\(^1\) with a formative element to support ongoing learning and implementation of the service.

Specific indicative plans for specific evaluation of risk stratified will include developing metrics highlighted in this bid such as number of patients put onto supported self-management pathways, tracking of outpatient appointments used, tracking follow-up and surveillance patients and reutilisation of capacity. The implementation plan will also include metrics for monitoring patient experience, quality of life and cost effectiveness.

Performance against these metrics will be monitored at a local STP and an Alliance level.

---

<table>
<thead>
<tr>
<th>Evaluation and Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation against these metrics will be “live” throughout the project and the results will inform changes throughout the duration of the project. It will also inform future commissioning decisions beyond the end of the life of any national funding.</td>
</tr>
<tr>
<td>Because monitoring will take place at an Alliance level as well as a local level, there will be Alliance-level discussions on performance and opportunities for sharing learning across all STP areas. The Alliance management team is well connected to national networks and have existing embedded mechanisms for sharing learning on a national basis.</td>
</tr>
</tbody>
</table>
Appendix 1 -
The South West vision is for all patients to receive the four key elements of the recovery package (Holistic Needs Assessments, Treatment Summaries, Cancer Care Reviews and Health & Wellbeing Events) regardless of geographical location, or tumour site.

Inputs
Transformation Funding

To support—
Formation of transformation task force for coordination across footprint and to provide strategic and clinical leadership
Support workers—in post to help implement the recovery package, become experts in community LWBC provision and free up CNS capacity.
Include training (see activities)
AHP—to support the implementation and delivery of recovery package (see training, see activities)
Project Management and analysis resource
IT infrastructure

Activities
Workforce model—understand and implement skill mix required to deliver LWBC
HNAs.
Taskforce to coordinate and optimise current projects
Invest in IT infrastructure for e-HNAs
Training for support workers and AHPs (to include prehabilitation work)
Training for CNs, support workers etc in advanced psychosocial support and communication
Treatment Summaries
Taskforce to coordinate and optimise current projects, following mapping of services and projects.
Design and share best practice template
Cancer Care Reviews
LWBC training for GPs and practice nurses to improve quality of cancer care reviews.
H&W
Taskforce to use existing programmes and resources, to coordinate and develop a rolling programme, tapping into community and online resources to ensure all have access when needed.

Evaluation—detail about approach in bid

Outputs
Improved workforce skill mix—freeing up capacity in the system for appropriate skills to be used for the different parts of the package
Every patient receives an HNA at key stages on their pathway, including an early HNA to prepare them pre-treatment. This is quality and informed by the patient.
Support workers become the expert in the community landscape of services which suit individual patient needs, patients receive access to services they require.
Existing services which support LWBC are utilised and achieve maximum impact.
Opportunities to fill gaps in provision are identified.
Every patient receives a treatment summary following every phase of completed acute treatment for sharing with primary care and community as appropriate.
A South West best practice treatment summary template is issued.
GPs attend Cancer Care Review training.
Patient receives quality cancer care reviews Rolling programme of H&W events/clinics which patient can access to at point of need (not just end of treatment / beginning of treatment)

Outcomes
All cancer patients can say “I am ready for my treatment”, “I am supported as a whole person” and “I am in control” and staff, volunteers and carers can say “I am supported to give the support cancer patients/family members need”
Patient experience improves due to access to the type of support they need when they want it.
Patients feel empowered to manage their condition, improving their quality of life.
Side effects and consequences of treatment/occurrence are identified sooner and an improvement in outcomes is identified.
Take up of healthy lifestyle advice and access to services leads to positive behaviour change that could lower risk of recurrence and improve quality of life.
Financial savings associated with reduction in follow up.
### Appendix 2 – Local Detail

<table>
<thead>
<tr>
<th><strong>Work</strong></th>
<th><strong>Key Current and Planned Local Projects</strong> – summary of mapping of achievement and plans at a local level, showing how they support the alliance</th>
<th><strong>Transformation Fund Plans</strong></th>
</tr>
</thead>
</table>
| Recovery Package – HNAs | **Summary**
Use of HNAs is varied across the footprint; however majority of areas already have an established work plan to increase the use of eHNAs to all cancer tumour sites. This includes use of support workers to free capacity of Cancer nurse Specialists, training in Living Well With and Beyond Cancer with a focus on psychological support and communication. Sites that do not currently use eHNAs are planning for the provision of electronic devices to members of staff and have IT projects in development to link information to Patient Systems. **Peninsula Alliance**

**Devon** – Implementation of HNAs across all sites have commenced with majority already in place. Work to accelerate the filling of gaps, support e-HNAs and where not already done so, embed onto pathway.

**Cornwall** – Implementation has commenced across all tumour sites. Plans to improve some tumour sites where HNA are delayed or incomplete. | 1. Taskforce to work with all providers to establish a uniform level of service across the Alliance that will be delivered according to local patient needs and optimising existing resource from local projects.

2. Recruit band 4 support workers to work with nurse specialists and primary care to develop the Recovery Package intervention. Training and support will build on existing exemplars in the Alliance and nationally and use technology to drive both delivery and improvement. This system wide collaboration will be supported by hand held electronic devices to support the use of HNA and care planning at more points in the pathway and to support integration of information with patient information systems.

3. We will build on the good work done already, learning from areas of success and best practice – for instance scaling up the work of NBT and UHB further, following their experiences in the NCSI pilot. This will be supported by the peer review and standard development strand of the programme and analysis of the specific local needs from HNA. For example, patients in Devon more commonly cite caring for an elderly relative as the main need, which is not highlighted nationally (see appendix 5).

4. We will work with specialist teams to identify specific elements of Holistic Needs assessment to be delivered by specialist teams and pilot delivery of broader assessment within the community supported by support workers as outlined above. |
<table>
<thead>
<tr>
<th>Treatment Summary</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of treatment summaries is varied across the footprint; however majority of areas already have an established work plan to increase use to all cancer tumour sites. This includes use of support workers to free capacity of Cancer nurse Specialists, and training.</td>
<td></td>
</tr>
</tbody>
</table>

**Peninsula Alliance**

- **Devon** – Limited use currently. Plans to establish a standardised template with site specific information. Currently being patch tested at RD&E with plans to adapt and spread across in a phased manner.

- **Cornwall** – Currently no treatment summaries are being used. Working as part of the Somerset Cancer Register Development Group for developing the functionality and flexibility of the summaries to enable test sites to commence, before wider implementation takes place.

<table>
<thead>
<tr>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The taskforce will work with stakeholders to develop treatment summaries that reflect patient’s individual needs as a single entity, as well as being accessible to the patient - supporting the development of a best practice template for sharing across the Alliance.</td>
</tr>
<tr>
<td>2. We will strengthen collaboration between primary and secondary care to ensure patients specialist needs are met whilst moving earlier to the community setting for those assessments and interventions that can be delivered closer to home.</td>
</tr>
<tr>
<td>3. We will recruit band 4 support workers to work with nurse specialists and primary care to develop the Recovery Package intervention. Training and support will build on existing exemplars in the Alliance and nationally and use technology to drive both delivery and improvement.</td>
</tr>
<tr>
<td>4. We will build on the good work done already, learning from areas of success and best practice to implement standardised templates.</td>
</tr>
<tr>
<td>5. Evaluate against progress from the baseline. (See Details)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer Care Reviews</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer care reviews are produced to a high % by primary care as part of QOF incentives. However the majority of footprints are looking to improving the</td>
<td></td>
</tr>
</tbody>
</table>

| 1. Taskforce will work with primary care to develop an enhanced cancer care review template that promotes self- |
## Scale up best practice

### Peninsula Alliance

**Devon** – Some education in LWBC and Cancer Care Reviews provided for GPs. Look to complement Alliance work on improving quality of Cancer Care Reviews, as well as expanding education provision to Practice Nurses. Torbay and South Devon are exploring use of virtual MDTs to support management of cancer in the community and at end of life.

**Cornwall** - Some education in LWBC and Cancer Care Reviews provided for GPs. Look to complement Alliance work on improving quality of Cancer Care Reviews, as well as expanding education provision to Practice Nurses.

### Cornwall

Some education in LWBC and Cancer Care Reviews provided for GPs. Look to complement Alliance work on improving quality of Cancer Care Reviews, as well as expanding education provision to Practice Nurses.

## Test then scale up best practice

### H&W

#### Summary

Majority of providers provide H&W events, services and clinics, however the type of support provided varies.

**Peninsula Alliance**

**Devon** – Both specific and generic Health and Wellbeing events/clinics are in place – frequency varies. Specific H&W is also available at Plymouth for TYA, gynae, sarcoma and more. Plymouth also has a comprehensive online resource to support this. RD&E have implemented a urology site-specific H&W clinic for pre-surgical patients: positive feedback. Plans are to increase frequency of events, and roll out HWB for all patients.

**Cornwall** – Both specific and generic Health and Wellbeing events/clinics are in place – frequency varies. Plans More work will be undertaken by the Cove to understand the needs and wishes of our cancer patients to determine the future model of service delivery. This is in line with STP ethos of treating patients close to management and offers psychological support.

### Peninsula Alliance

1. The Alliance will develop a programme of coordinated health and wellbeing events, self-management courses/events available to people affected by cancer who are living in the Alliance.

2. Building on existing events/courses we will have a flexible programme of community and online resources that give people choice to decide what support they need and when and how they access it.

3. It is also acknowledged by the Alliance, that peoples’ needs change over time. We want to work with NHS and voluntary sector organisations to meet the needs of our population. Everybody with a cancer diagnosis would
<table>
<thead>
<tr>
<th>Test then scale up best practice</th>
<th>home and increasing capacity to self-manage. This approach is more applicable to some cancer sites than others</th>
<th>receive the information on the rolling programme of activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4. Evaluate (see details)</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 3 – PARNTERS

### Peninsula Cancer Alliance Board Members

<table>
<thead>
<tr>
<th>CCGs</th>
<th>Providers</th>
<th>Tertiary providers</th>
<th>Population</th>
<th>STPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kernow</td>
<td>Northern Devon Healthcare</td>
<td>Plymouth Hospital</td>
<td>1.7 million</td>
<td>Cornwall and the Isles of Scilly</td>
</tr>
<tr>
<td>NEW Devon</td>
<td>Plymouth Hospitals</td>
<td>Royal Devon &amp; Exeter</td>
<td></td>
<td>Devon</td>
</tr>
<tr>
<td>South Devon &amp; Torbay</td>
<td>Royal Cornwall Hospitals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Royal Devon &amp; Exeter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Torbay &amp; South Devon</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
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</tbody>
</table>
## Appendix 4
### How the Proposal Support each STP

<table>
<thead>
<tr>
<th>STP</th>
<th>Plans</th>
</tr>
</thead>
</table>
| Devon | Devon  
5 yr. programme of sustainability:  
“we will not achieve the radical and transformational system outcomes we are striving for - unless we change our view from functional and organisational to people, place, systems ....through joint working of statutory partners and the voluntary and charitable sectors.”  
The STP will provide an overarching strategic framework, within which people residing in wider Devon and Cornwall will experience sustainable, integrated, place-based support.  
The implementation of a major programme of transformational change and improvement which:  
- Promotes independence and prevention  
- Responds to the physical and mental health and care needs of people across Devon  
- Provides an integrated network of support that is safe, sustainable and affordable  
Enables people to live their lives well. |
| Cornwall and the Scilly Isles | 1. Increased Prevention – Primary and secondary prevention will focus on public health and improvement in a number of lifestyle factors which include weight management, uptake of activity and reduction in risky lifestyles (reduced alcohol intake and smoking). The STP recognises that the Cornish population has a high level of obesity which is a significant risk factor for cancer alongside increasing age. We also know that the number of over 65s will grow faster than the general population so we are expecting the number of diagnosed cancers to continue to increase in the short to medium term at least.  

2. Integrated care in the community – Increased uptake of self-care following cancer treatment, supported by the Cove with a 6 month cancer post treatment review carried out by general practice. The Cove will offer a holistic service on a cancer site basis. More work will be undertaken by the Cove to understand the needs and wishes of our cancer patients to determine the future model of service delivery. This is in line with STP ethos of treating patients close to home and increasing capacity to self-manage. This approach is more applicable to some cancer sites than others, self-management for prostate is well established with the PSA tracker, there is scope to extend colorectal follow-up, other urological and gynaecological malignancies could follow.  

Vulnerable GP services – the introduction of GP clusters has the potential to develop expertise at a population level of 30-50,000 which would enable increased capability in the identification, triage and early diagnosis of cancer. There are opportunities within the workforce model to integrate stratified pathways of care. |
3. **Pathways of Care** – Cancer pathways are one of the priorities within this section of our STP. The NHS England RightCare programme tells us that the Secondary care (RCHT and PHT) provision in Cornwall are relatively high cost (compared to peer group) which will be investigated at a tumour site level, likely to lead to reduced length of stay for some procedures, exploring the potential of prehabilitation to improve patient experience, outcomes and length of stay. This could be provided as part of a community service.

4. **Workforce Model** – pathway review will lead to the development of the support worker workforce trained in holistic needs assessment, advice lines, signposting and remote monitoring forming the Recovery Package will be considered as cancer pathways are reviewed under the STP. This will release time for our specialist nurses to focus on more interventional practice. This aspect of care will need supporting by the development of an integrated care record, with accessibility across the pathway. The IT roadmap will have the potential to link patients to remote monitoring, portals and accelerate the uptake of integrated records.

5. **Diagnostics** - Straight to diagnostic testing will be considered within the Trusts diagnostic strategy which links to the STP community delivery model and the reconfiguration of community hospitals and urgent care facilities.
Appendix 5

**Top 10 concerns burdening people with cancer**

Perceptions of patients with cancer and the nurses caring for them

Authors: Keith Mitchell, Sarah Delfont, Maria Bracey & Ruth Endacott

One means of ensuring that the needs of people with cancer are identified in a comprehensive manner is through the Holistic Needs Assessment (NCSI 2012):

- Used recently to identify the top ten concerns (TTC) of people with cancer (Macmillan 2015, Kuczewska et al 2015).
- Validated with a sample of 5421 with good internal consistency and construct validity (Snowden & Fleming 2015).

**Electronic Health Needs Assessment (e-HNA)**

Data collected over an 18 month period from an Electronic Health Needs Assessment tool (e-HNA) from 5 cancer sites (n = 1233 patients).
- Colorectal
- Breast
- Gynaecological
- Skin
- Urology

Breast and gynaecological cancer groups both recorded significantly higher median Distress Thermometer scores than urology, skin and colorectal cancer sites.

**Outcomes**

- Helped us shape a more person-centred H&WBC.
- Contributed to identifying a need for a site specific HWBC to include generic information.
- Frequency and timing of when our H&WBC would be held.

**TOP TEN CONCERNS (TTC)**

- A subgroup of urology patients needed more individualised information.
- Nurses identified between 3-6 of the TTC expressed by patients, with a wide variation across each site.
- The national average TTC identified by Macmillan (2015) were identified as a concern for between 2.7 and 29.8% of our patients.

Using the data information we have worked in collaboration with our independent cancer support centre FORCE to tailor the information needs for our Health and Wellbeing Clinics (H&WBC).

**The Clinics**

- Patients automatically given a H&WBC appointment within 31-62 days of their diagnosis.
- Clinics held 3-4 times a month.
- Each session evaluated.
- Clinics now include all cancer sites.

**Broader Evidence Base**


Appendix 6

Number of people diagnosed with cancer 2015/16 and growth projections to 2018/19

*New Patients counted from 31 first definitive treatments*

<table>
<thead>
<tr>
<th>Year</th>
<th>Breast</th>
<th>Colorectal</th>
<th>Urological</th>
<th>Sub-total</th>
<th>Lung</th>
<th>Skin</th>
<th>Other</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>1,758</td>
<td>1,282</td>
<td>2,214</td>
<td>5,254</td>
<td>1,095</td>
<td>3,305</td>
<td>2,992</td>
<td>12,646</td>
</tr>
<tr>
<td>2016/17</td>
<td>1,760</td>
<td>1,284</td>
<td>2,202</td>
<td>5,246</td>
<td>1,091</td>
<td>3,316</td>
<td>3,004</td>
<td>12,658</td>
</tr>
<tr>
<td>2017/18</td>
<td>1,761</td>
<td>1,287</td>
<td>2,191</td>
<td>5,239</td>
<td>1,088</td>
<td>3,327</td>
<td>3,016</td>
<td>12,670</td>
</tr>
<tr>
<td>2018/19</td>
<td>1,763</td>
<td>1,289</td>
<td>2,179</td>
<td>5,231</td>
<td>1,084</td>
<td>3,338</td>
<td>3,028</td>
<td>12,682</td>
</tr>
</tbody>
</table>

Growth rates from CRUK

<table>
<thead>
<tr>
<th>Increase from 2014 to 2035</th>
<th>2%</th>
<th>4%</th>
<th>-11%</th>
<th>-7%</th>
<th>7%</th>
<th>2%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual increase</td>
<td>0.1%</td>
<td>0.2%</td>
<td>-0.5%</td>
<td>-0.3%</td>
<td>0.3%</td>
<td>0.10%</td>
</tr>
</tbody>
</table>
Appendix 7

Financial Benefits

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2018/19</th>
<th>Recurrent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Follow Ups @ £87</strong></td>
<td>319</td>
<td>1595</td>
<td>3191</td>
</tr>
<tr>
<td><strong>Savings</strong></td>
<td>6,947</td>
<td>277,871</td>
<td>277,871</td>
</tr>
<tr>
<td><strong>% recurrent savings realised</strong></td>
<td>10%</td>
<td>50%</td>
<td>100%</td>
</tr>
</tbody>
</table>

These savings will be shared between Recovery Package and Risk Stratified Pathways bids. This is due to the difficulty in attributing one set of savings to each element. The savings will be monitored as part of the evaluation which will take place across the Recovery Package and Risk Stratified Pathways section of the bids, in order to understand what impact is being seen. Greater confidence will be provided in these figures as the project goes on. If the above is seen, this will support the argument for sustainability of the elements of the Recovery Package and Living Well With and Beyond Cancer. However it must be noted that it is anticipated that these savings are non-cashable, as the released capacity will be used elsewhere in the pathway (i.e. time used to fill out HNAs etc.). The evidence base below demonstrates what we might expect to see.

Changing the way care of cancer survivors is delivered should deliver efficiencies and non-cashable savings in other areas of the pathway. Savings can be expected as follows:

**Reduction in hospital follow up**

Some areas have already prepared changed models of follow-up by using the Recovery Package. For example, for patients with low grade lymphoma, the current pathway for patients with stage 1 disease post treatment is 17 follow-ups over 10 years, at a cost to the commissioner of £2,082.50. For stage 2-4 disease there are 25 appointments in 10 years at a cost of £2,450. The proposed pathway based on use of the Recovery Package involves six appointments (including two nurse led HNA specific appointments) plus an H&W event, at a total cost of £715. Whilst exact figures will vary depending on the pathway and the risk-stratified assessment, at least one doctor-led follow-up should be saved in all pathways, once the Recovery Package is fully implemented. This releases capacity in the system.

**Reduction in length of stay and complications**

The cancer support workers are essential to the prehabilitation programme which has been shown to have significant benefits. A more detailed prehabilitation package may be worked up for potential commissioning in future years, alongside the Recovery Package. Early results from this initiative, which is being expanded, show that the average length of stay for patients is reduced by 7.5 days following oesophagectomy, 2.6 days following gastrectomy, and 6.3 days following Whipples pancreatecticiudodenectomy in patients who undergo the prehabilitation programme. A similar programme at Heartlands Hospital for lung patients also showed a 7.3% reduction in complications, a 10.4% reduction in hospital readmissions and a 0.3% reduction in ITU admissions, equating to per patient savings of £1,257.42 for commissioners at a cost of £188 per patient.

**Reduction in hospital contacts**

Research by the Nuffield Trust published May 2014 shows that use of hospital services by cancer patients remains significantly higher than expected at 15 months after diagnosis, with 60% more ED attendances, 97% more emergency admissions, four times more outpatient attendances and nearly six times more elective admissions, than expected. This highlights the ongoing additional needs of cancer patients after

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2. Use of Health and Social Care by People With Cancer (Nuffield Trust, 2014)
CANCER TRANSFORMATION FUNDING

the initial treatment period, and the need for better recovery/survivorship programmes to reduce emergency contacts in particular. NHS Improvement test sites have shown early results suggesting the self-management as part of stratified cancer follow-up pathways reduces oncology follow-up attendances, readmissions and use of bed days. A study in Manchester has suggested that a saving of £1,000 per patient should be possible by introducing stratified follow-up, pathway efficiency and better co-morbidity management. Some types of Recovery Package assessment replace an existing follow-up appointment, and are thus cost neutral. However it should be noted that the input and out-of-clinic support needed to follow through some of these interventions is greater than that for a conventional appointment.

Non-financial Benefits

- **Reduction in use of other services.** Research shows that patients who have had a cancer diagnosis have 50% more GP contacts than expected even by 18 months after diagnosis. Better supported, educated patients are less likely to access services unnecessarily, and more likely to have complications identified early. Earlier management of many conditions leads to better outcomes and less intense intervention.

- **The support provided directly to patients by the Cancer Support Workers may also increase efficiency and reduce chargeable contacts.** For example, reducing non-attendances by resolving transport issues for patients, seeing patients ad hoc in the information centre to provide information and support, reassuring the patient and reducing the likelihood of them requiring a potentially unnecessary appointment.

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5 Adult Survivorship: From Concept to Innovation (NHS Improvement, 2012)
6 Allirajah D. Demonstrating the economic value of co-ordinated cancer services. An examination of resource utilisation in Manchester (Macmillan Cancer Support, 2010)