

A Pathway to Sustainable Innovation: Best Practice in Cancer Care



Bristol-Myers Squibb

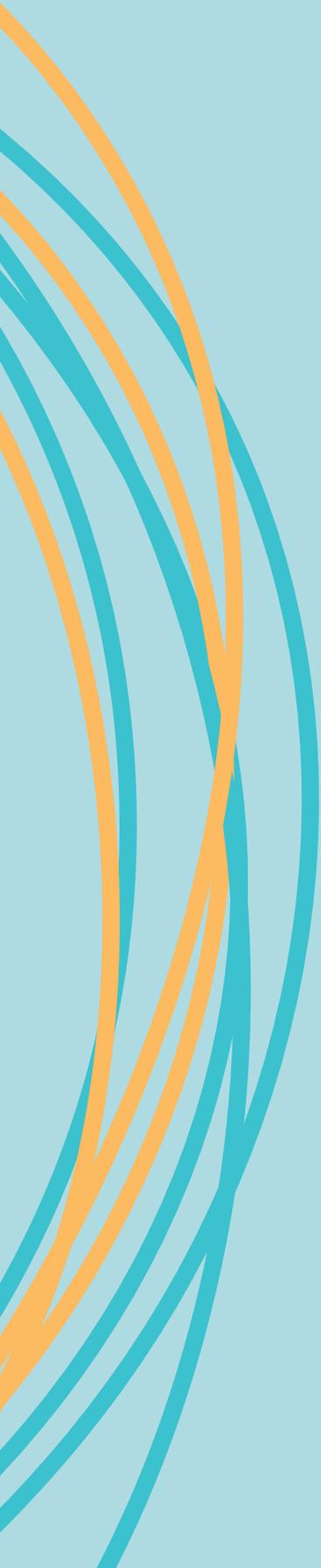
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Bristol-Myers Squibb worked in partnership with the Patients Association on the initiation of this project and funded the administrative costs associated with the creation of this report, but this report was produced based on the input of All.Can Working Group members and does not represent the opinion of Bristol-Myers Squibb.



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Foreword - Rachel Power, Chief Executive of the Patients Association

How we can best support people with cancer is one of the many major challenges facing the NHS in the UK. Half of us can now expect to receive a cancer diagnosis in our lifetime, and more than 350,000 people are already being directly affected by the condition every year.¹ It is therefore essential that the health service is doing the best job it can to support these patients, particularly at a time when there is a lack of funding and savings need to be made.

The Patients Association's mission is to give effect to the patient voice, to improve patient experience and support people to engage fully in their own care. We are therefore delighted to be working with Bristol-Myers Squibb and the All.Can UK Working Group on this project, which aims to demonstrate how adopting best practice in cancer services can transform the care patients receive while making better use of NHS resources at the same time. A number of clinicians and charities across the country have successfully implemented new ways of delivering care; some of which have required service redesign, whilst others needed only minor changes to current practice. The challenge is now to find a way of replicating the work done by these leading lights on a larger scale.

Changing the way the NHS works is often a difficult and slow moving process. However, with the introduction of the new Cancer Alliances across England, we hope they will offer a fantastic opportunity to bring services together and to find new ways of doing things. I hope that the examples included in this report demonstrate how the barriers that often stop service redesign ideas from being adopted can be overcome and the benefits that new approaches might bring. My aim is that this approach can, in time, also be adopted for other disease areas as well.

I hope you find this report to be of use and we look forward to hearing your feedback.

Rachel Power
The Patients Association
January 2018



About All.Can

All.Can is an international initiative that aims to engage policymakers on the need to improve the efficiency of cancer care, focusing on better outcomes for patients. Our aim is to identify ways we can optimise the use of our resources in cancer care. The All.Can group comprises of leading representatives from patient organisations, policymakers, healthcare professionals, research and industry from across Europe and Canada. In the UK, All.Can is supported by Bristol-Myers Squibb and chaired by The Patients Association. It brings together an All.Can Working Group of charities and clinicians from across the UK cancer space to discuss ways to improve cancer care by encouraging the wider uptake of best practice care.

The UK Working group's first report, **Transforming the Cycle in Cancer Care**, was published in March 2017. Further details relating to the All.Can project can be found here:

www.all-can.org/about

Executive Summary

- Cancer is one of the major health issues facing the UK. Almost 1,000 people are diagnosed with cancer every day.ⁱ
- The NHS is under considerable financial pressure and needs to find sustainable solutions to improve care over the coming years. Cancer already costs the UK economy more than £16bn a year, a considerable burden.ⁱⁱ
- NHS England has established Cancer Alliances that can co-ordinate improved care across different Trusts and services, and support the uptake of best practice.ⁱⁱⁱ
- However, the All. Can UK Working Group has identified five barriers that prevent best practice from being implemented more widely across NHS cancer services. These are:
 - Identifying best practice;
 - Limited staff capacity and a lack of required skills amongst the NHS workforce;
 - The cost (upfront and ongoing) of implementing service redesign;
 - Resistance to cultural change within the health service due to a lack of data; and
 - An embedded 'silo' approach and a resistance to collaborative working.
- This report identifies a number of best practice case studies that have overcome these barriers. These demonstrate both **improved patient outcomes** and **a more effective use of NHS Resources**. They can also help to meet Cancer Strategy Targets, such as the 62 day standard and encouraging early diagnosis.^{iv}
 - A new **pancreatic cancer surgical pathway** has saved one Trust almost £100,000 in its first year and helped 31 patients receive treatment in just 16 days.^v
 - A best practice service for bladder cancer has improved patient outcomes and experience, and reduced hospital stays from 12 day to seven days.^{vi}
 - Changing the way that urine samples are collected can significantly **improve the chances of diagnosing certain cancers at an early stage** while also delivering **10% cost savings**.^{vii}
 - Involving patients in service feedback has helped breast cancer centres significantly, improving local outcomes and **patient experience**.^{viii}
- Following the example of these case studies can help each of the challenges laid out above be overcome. In addition, in order to offer practical help to Cancer Alliances and NHS services looking to adopt best practice, this report also features a template business case document that can be used to make the case for real change locally.

Introduction

Cancer affects more than 350,000 people and causes more than 160,000 deaths in the UK a year.ⁱ One in two people born in Britain after 1960 can now expect to receive a cancer diagnosis during their lifetime, despite more than 40% of cases being deemed preventable.ⁱ As a result, cancer is a significant cost to the UK economy; estimated at more than £16 billion a year, only a third of which relates to direct healthcare expenditure.ⁱⁱ



The **NHS Five Year Forward View** makes it clear that the health service faces considerable financial challenges but that ‘there are viable options for sustaining and improving the NHS over the next five years’.^{ix} In order to help cancer services play their part, Bristol-Myers Squibb and The Patients Association have convened the All.Can Working Group of experts to look at how care can be improved whilst also using NHS resources efficiently. Specifically, the All.Can Working Group has looked at how examples of best practice care can be introduced more widely in order to break the ‘negative cycle of cancer’, where a short-term approach can often lead to increased longer-term costs.^x

Purpose of this report

In order to achieve the ambitious vision set out by the **Cancer Strategy**, the NHS has established a network of Cancer Alliances across England.ⁱⁱⁱ^{iv} These will sit across the same geographical footprints as Sustainability and Transformation Plans and aim to bring together commissioners and clinical leaders in order to transform cancer services.ⁱⁱⁱ As such, alongside the National Cancer Vanguard, they will be at the forefront of the dissemination of best practice.

The All.Can Working Group’s initial report, **Transforming the Cycle in Cancer Care** (2017), identified that widespread adoption of best practice across services could offer considerable benefits to both the NHS and the patients who use them.^x This second report looks at how we can turn exceptional services into the standard of care across the NHS. It is hoped that the recommendations, best practice case studies and business case template included will provide a blueprint for Cancer Alliances to implement transformational change to the way cancer services are designed and ultimately, care is delivered to patients.

Please note that this report is based on discussions and considerations made by the Transforming the Cycle in Cancer Care Working Group.

What are Cancer Alliances?

NHS England has established 19 Cancer Alliances (including the three Vanguard sites) following recommendations from the Independent Cancer Taskforce. The Alliances are intended to bring together different providers and commissioners to “take a whole population, whole pathway approach to improving outcomes across their geographical ‘footprints’, building on their relevant Sustainability and Transformation Partnerships (STPs)”.ⁱⁱⁱ They have been tasked with “leading transformations at scale to improve survival, early diagnosis, patient experience and long-term quality of life”.ⁱⁱⁱ In particular, they have been asked to take action that focuses on improving the 62 day from referral to first treatment standard and other elements of the CCG Improvement and Assessment Framework.ⁱⁱⁱ

The new Cancer Alliances have been tasked with delivering their goals by:

- Coordinating a new way of collaborative working across their locality, aligned with Sustainability and Transformation Plans.
- Managing and directing a proportion of additional “Cancer Transformation Funding”. This money will be specifically targeted at improving services for: earlier diagnosis, the “Recovery Package”; and stratified follow up pathways.
- Aligning with new service models for cancer.
- Working with the National Cancer Programme team on particular national initiatives, such as development of a national framework on roll out of the 28 day faster diagnosis standard; helping to coordinate targeted support to CCGs, in particular on improving performance against the 62 day standard; and, engaging with the 100,000 Genomes Project.ⁱⁱⁱ

Challenges to Best Practice Implementation

Despite the clear recommendations around best practice adoption set out by both our initial report and NHS guidance, it is evident that the Cancer Alliances are likely to experience a number of systemic challenges which can prevent the wider dissemination and implementation of best practice in NHS cancer services. According to the All.Can Working Group, these challenges include:

- Identifying best practice;
- Limited staff capacity and a lack of required skills amongst the NHS workforce;
- The cost (upfront and ongoing) of implementing service redesign;
- Using data to create cultural change within the health service; and
- An embedded 'silo' approach and a resistance to collaborative working.

These barriers are not insurmountable. There are a number of case studies that show how these challenges can be overcome in order to implement better and more efficient patient care. In order to demonstrate how best practice can be efficiently adopted, we have looked at each of the above five challenges and detailed how they can be overcome to enable service redesign.

Challenge 1: Identifying Best Practice

Before a Cancer Alliance can consider how it can redesign services to achieve better outcomes, it has to identify what best practice looks like. To address this, criteria should be applied to judge:

- Whether service redesign attempts are 'best practice'; and
- Whether they can be replicated more broadly across different types of cancers and cancer services.

It will also be important to demonstrate how best practice can help deliver the objectives set for Cancer Alliances and the key goals within the Cancer Strategy.

One approach to identifying and disseminating NHS best practice has been established in Wales as part of the work of The Bevan Commission. The Commission was set up in 2008 to ensure the Welsh health service "can draw on best practice from across the world while remaining true to the principles of the NHS".^{xi} As such, a small number of criteria have been adopted to identify which best practice pilot schemes it supports.^{xii} These are illustrative of what might be applied to examples of best practice across cancer services in the rest of the UK.

Identifying the Right Approach' – the Bevan Commission Criteria^{xii}

- **Is the idea "Prudent?"**
(ideal answer: yes)
- **Can this be delivered within 9 – 12 months?**
(ideal answer: yes)
- **Is it scalable?**
(ideal answer: yes)
- **Is this idea new and innovative?**
(ideal answer: yes)
- **Is this project something I'm familiar with and have been doing for a while?**
(ideal answer: no)
- **Is it certain that this idea will work?**
(ideal answer: no)
- **Has it got a good a chance of working?**
(ideal answer: yes)
- **Will we learn something new from supporting this idea?**
(ideal answer: yes)

The Bevan Commission does not necessarily expect the ideal answer to be met by all case studies, but this does give an indication of the extent to which a case study can be described as 'best practice'.

These criteria aim to support ideas that are deliverable, scalable, have a good chance of working and offer value for money; they also acknowledge that not every attempt at service redesign will be a success first time. In this way, innovative approaches in NHS service design can be fostered and supported.

In addition to the above, the All.Can Working Group considers it essential that the patient voice is considered in the development of all service redesign projects.

For Cancer Alliances, it is also important to consider whether any example of new best practice also helps to achieve the priorities identified by NHS England in the Cancer Strategy. The current priorities for delivering the Strategy fall under the following 6 categories:

- Prevention and public health
- Earlier diagnosis
- Patient experience
- Living with and beyond cancer
- Investment in a high-quality, modern service
- Commissioning, accountability and provision.^{iv}

Finally, All.Can Working Group members argue that current pressures on NHS resources mean that limited money is available for service redesign in cancer beyond the extra funding being made available for specific projects relating to the Strategy. Another important category on which to judge a best practice example is therefore whether it is financially feasible – both in terms of the start-up costs associated with the service redesign, and the savings generated as a result.

Taking this all into account, the criteria set out above have been used throughout this report to indicate whether a case study demonstrates best practice.

The All.Can UK Best Practice Criteria

Best Practice Criteria	
<input checked="" type="checkbox"/> <input type="checkbox"/>	Can this be delivered within 9 – 12 months?
<input checked="" type="checkbox"/> <input type="checkbox"/>	Is it scalable and replicable?
<input checked="" type="checkbox"/> <input type="checkbox"/>	Is this idea new and innovative?
<input checked="" type="checkbox"/> <input type="checkbox"/>	Is this project something I'm familiar with and have been doing for a while?
<input checked="" type="checkbox"/> <input type="checkbox"/>	Has it got a good a chance of working?
<input checked="" type="checkbox"/> <input type="checkbox"/>	Has the patient voice been considered?
<input checked="" type="checkbox"/> <input type="checkbox"/>	Does it support the Cancer Strategy Priorities?
<input checked="" type="checkbox"/> <input type="checkbox"/>	Is it financially feasible?

Challenge 2: Limited Staff Capacity and Required Additional Skills

Justifying the redesign of services and reallocation of budgets typically requires a 'business case' to be made to budget holders and other senior staff. However, between 2010 and 2015 there was an 18% reduction in the number of managerial staff employed by the health service.^{xiii} This reduced the number of staff with the skills needed to develop these business cases, with clinical staff often lacking capacity.

One way that this barrier can be overcome is for Cancer Alliances to encourage units to work with external providers – such as charities – to develop a service redesign proposal. This approach has been demonstrated by Breast Cancer Now's **Service Pledge**.

Case Study Name: Breast Cancer Now¹ Service Pledge

Overview: The Service Pledge programme helps breast cancer services across the country involve patients and staff in reviewing services and implementing patient-centred improvements so that all breast cancer patients receive high quality treatment and care.^{viii}

Activity: Working with patients and staff, Breast Cancer Now gathers feedback on the current service through surveys, interviews and workshops. The responses are reviewed and each site is presented with a report outlining the findings of the consultation.^{viii xiv}

The 'Pledge Leads' (members of the NHS team trained by the charity), patient representatives, breast unit staff and Breast Cancer Now staff then meet to discuss and agree improvement goals. Examples include:

- Recruiting extra consultants to increase the number of breast clinics a hospital runs
- Providing tailored information for men with breast cancer
- Setting up a patient buddy system^{viii xiv}

These agreed goals form the basis of the 'Service Pledge'. The charity covers the cost of key elements to develop the Service Pledge, including any travel and accommodation costs required during its development.

The success of the pledge can then be evaluated over time, with ongoing results and feedback used to refine the process at a later date.

Outcomes:

- Skills gaps are filled and the workload of the cancer service is reduced, while still allowing best practice to be implemented
- To date, the Service Pledge has helped improve experiences for over 30,000 patients at more than 90 hospitals across the UK
- Ipswich hospital introduced a **new waiting list system, reducing waiting times**

- Grantham hospital opened a **new breast unit**, with a business case supported by their Service Pledge evidence, which increased activity by 25%
- As a result of patient involvement and the resulting improvements, many hospitals have reported a significant **reduction in patient complaints**. One hospital saw complaints reduce from five-six per day down to one per month
- Many hospitals have also reported an **increase in patient satisfaction** as patients feel they are really listened to, and able to help inform plans and improvements
- Units are provided with a tangible way to use patient feedback to redesign and improve care
- With Breast Cancer Now delivering much of the service redesign, the programme suffers fewer delays as a result of a lack of capacity within breast cancer units and staff turnover

The involvement of a charity partner gives additional credibility to the insights received from the patient community.^{xiv}

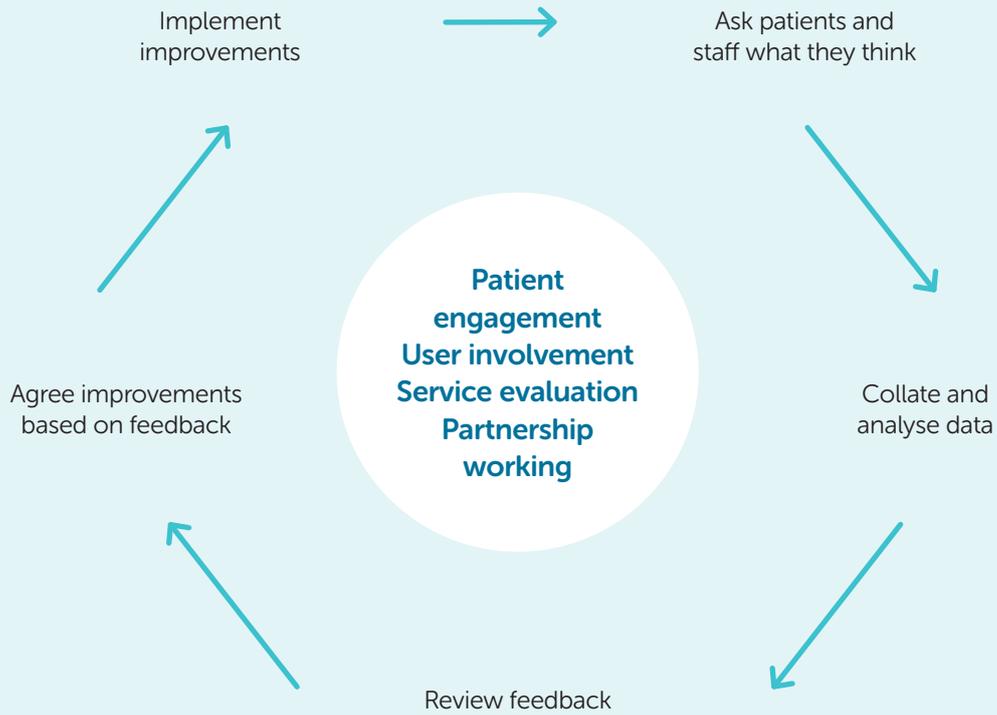
However, the NHS should not only rely on the third sector to deliver this support. The **Transforming the Cycle in Cancer Care** report suggested that NHS Improvement could play a role in supporting best practice. Cancer Alliances should also provide assistance to individual services looking to develop business cases for service redesign projects by pooling support and expertise across the network.

At the end of this report, a template business case is provided in the appendix.

¹ Breast Cancer Now is the UK's largest breast cancer charity.

Service Pledge methodology

This methodology is continually evaluated and refined using patient and healthcare professional review and feedback



Adapted from graphic produced by **Breast Cancer Now** ^{xv}

Does this Case Study Meet Best Practice Criteria?

Best Practice Criteria	Notes
 Can this be delivered within 9 – 12 months?	These examples of best practice should be deliverable within 12 months, despite difficulties with NHS capacity.
 Is it scalable and replicable?	This example of best practice has already been replicated at breast cancer units across the country. This suggests scalability in this tumour type – and potential scalability in other cancer services too.
 Is this idea new and innovative?	The project has existed for almost a decade but its focus on evaluation and feedback allows for new innovative examples of best practice to emerge regularly, although the programme isn't pioneering in itself.
 Is this project something I'm familiar with and have been doing for a while?	As above.
 Has it got a good a chance of working?	Success has been demonstrated at breast cancer services across the country, with outcomes improving over time.
 Has the patient voice been considered?	Patients are at the centre of this service redesign project.
 Does it support the Cancer Strategy Priorities?	Patient Experience is one of the key priority areas included in the cancer strategy. Individual Service Pledge outcomes vary, but different examples have also had other positive outcomes, such as waiting times.
 Is it financially feasible?	Breast Cancer Now has provided support for Trusts that wish to undertake the Service Pledge development process, limiting the cost impact on the NHS.

Challenge 3: The Cost (Upfront and Ongoing) of Implementing Service Redesign

Cost is a key barrier when considering whether to redesign services to achieve best practice – both upfront re-organisational costs and ongoing maintenance costs must be accounted for. However, the adoption of innovation can often result in immediate year-on-year savings, as well as those over a longer period. This is demonstrated by a new surgery pathway that has been developed for pancreatic cancer.^{xvi}

Case Study Name: A Fast Track Surgery Pathway for Pancreatic Cancer

Overview: Surgery within a few weeks of diagnosis is often the only potentially curative treatment for patients with pancreatic cancer. Delays can result in patients receiving treatment for jaundice, which involves preoperative biliary drainage (PBD), a procedure that can be distressing and put patients at risk of developing complications. This is despite an emerging evidence showing complications associated with PBD when jaundiced patients are fit enough to receive surgery without pre-operative interventions.^v

Mr Keith Roberts, Consultant Hepatobiliary and Pancreatic Surgeon, and the team from University Hospitals Birmingham redesigned the treatment pathway for patients awaiting surgery for this type of disease in order to reduce costs and improve outcomes. The start-up costs of £100,000 were provided jointly by Pancreatic Cancer UK and by University Hospitals Birmingham Charities.^{xvi} Pancreatic Cancer UK² supported development of the pathway by giving a Clinical Pioneer Award (a financial bursary) to Mr Roberts.

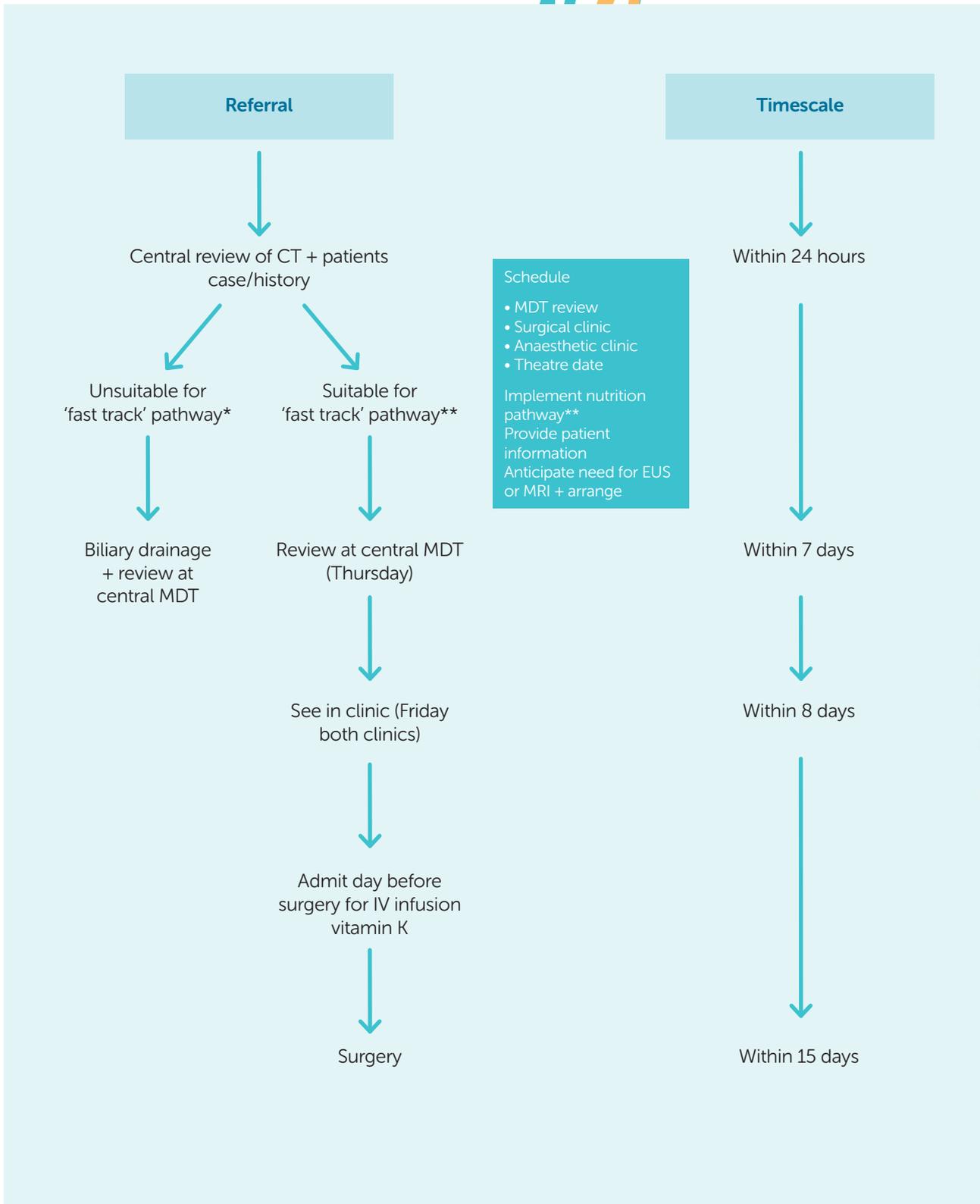
Activity: Recognising that patients still receive PBD ahead of surgery because of a lack of resources available to redesign care pathways, University Hospitals Birmingham secured an upfront investment for a fast track pathway for pancreatic cancer patients.^v

The patient presents with jaundice in the referral unit. If the clinicians suspect pancreatic cancer on the basis of the presentation and initial CT scan, they are referred directly to the fast track surgery pathway which involves surgery without PBD intervention first. The patient will be reviewed by the specialist multi-disciplinary team (MDT) and a diagnosis and suitability for the fast track surgery will be given within 24 hours. If suitable for surgery, then the patient will be seen within 7 days for clinical assessments and also consent from specialist CNS. Then, the patient will be given a surgery date within 7 days.^v

Outcomes: Within the first year, patients on the fast track pathway received surgery within 16 days on average, compared to 65 days for patients on the standard pathway undergoing PBD.^v

- Almost 20% more patients were resected when assigned to the fast track pathway compared to typical procedures.^v
- Each patient that avoided PBD reduced the costs of treatment by £3,200. With 31 patients undergoing surgery without the need for prior PBD, this saved £99,200 in a one year period – almost entirely recouping the set-up cost for the project within 12 months.^v
- Rates of unresectable cancers were decreased by at least a third when patients had to wait less than 32 days for surgery under the new pathway.^v
- There was limited impact on hospital surgical capacity as a result of the pathway being adopted, and beds allocated to the pathway that were not used were reallocated to other patients.^v
- Overall, the service redesign reduced the number of procedures a patient was required to have, as well as reducing the number of times that same person had to be discussed by a specialist MDT meeting.^v

² Pancreatic Cancer UK is a national charity supporting people with pancreatic cancer and research into this disease area.



Adapted from Promoting Innovative Practice showcase by Keith Roberts^v

Pancreatic Cancer UK supports innovations in care through its 'Promoting Innovative Practice-PIP' initiative (<https://www.pancreaticcancer.org.uk/pip>).

Further details of the pathway can be found in the HPB Journal (August 2017 Volume 19, Issue 8, Pages 713–720).

Does this Case Study Meet Best Practice Criteria?

Best Practice Criteria		Notes
✓	Can this be delivered within 9 – 12 months?	This case study has achieved measurable results within 12 months of being implemented.
✓	Is it scalable and replicable?	No special circumstances within the UHB service were identified that would stop the case study being replicated in other pancreatic cancer services across England. While the exact problem is not relevant in other tumour types, the principle of using money saved via service redesign projects to offset the cost of implementing best practice is likely to be applicable in a broad range of services.
✓	Is this idea new and innovative?	Yes
✗	Is this project something I'm familiar with and have been doing for a while?	No: although PBD is not recommended for all patients, many services continue to perform the procedure anyway.
✓	Has it got a good a chance of working?	Success has been demonstrated through both cost savings achieved and an increasing number of patients using the pathway.
✓	Has the patient voice been considered?	Individual patient case histories are considered when judging eligibility for the fast track pathway.
✓	Does it support the Cancer Strategy Priorities?	The fast track pathway significantly reduces time to treatment – aligning closely with the Strategy and Cancer Alliance prioritisation of the 62 day referral to treatment standard.
✓	Is it financially feasible?	While the pathway had some initial start-up costs, this was almost entirely recouped within the first year and indicating it will be significantly cost-saving in years to come.

Upfront spending can also help improve care earlier in the pathway while also delivering more cost-effective services. One example is the use of mid-stream urine testing for suspected cancers.

Case Study Name: Reducing Contaminated Urine Tests for Cancer Diagnosis

Overview: Urine tests can play a key role in diagnosing cancers, such as myeloma and bladder cancer.

^{xvii} ^{xviii} However, many samples collected in the UK are contaminated and therefore useless, delaying diagnosis. Adopting new processes for urine tests can improve patient experience as well as saving time and money for the NHS.^{vii}

Activity: Around 65 million urine samples are collected in the UK each year, which equates to 259,000 per day. Overall, 22.5% of these are thought to be unreliable owing to contamination – meaning that almost 60,000 patients undergo failed urine sample tests each day.^{vii} There is also considerable variation nationally, ranging from 0.08 - 70% contamination of samples, depending on the region.^{vii}

This is an important issue for cancer patients. A study conducted in 2006 found that certain types of urine tests could diagnose recurrent bladder cancers with a success rate of 99%.^{xix} It is therefore essential that these tests are conducted properly. For this reason, Public Health England has called for mid-stream urine (MSU)

to be the recommended routine collection method.

^{xx} Specimen collection kits have been developed that can collect urine samples “mid-stream” in order to achieve this goal.^{vii} Studies have found that using different equipment can significantly reduce the number of unused samples, while improving patient experience.^{vii}

Outcomes: A study of one new urine sample collection method covered 80,000 patients and saw the following results:

- A contamination rate of 1.5% compared to the national average of 22.5%.
- Despite an initial additional cost for specimen collection kits, the system saw a 10% cost saving over 80,000 patients – equating to savings of £78,344 overall, or £0.98 per patient.
- A 2017 study found that 94% of patients were confident using the new tool, 88% would be comfortable using it again and 70% would recommend it to others.^{vii}

Does this Case Study Meet Best Practice Criteria?

Best Practice Criteria	Notes
✓ Can this be delivered within 9 – 12 months?	No laboratory methodology would need to change to deliver this service, it would just be a case of changing supplier for urine sample kits.
✓ Is it scalable and replicable?	This could be adopted by services across the UK providing that the initial increased financial cost could be met.
✗ Is this idea new and innovative?	No, it is the recommended standard set out by PHE – however, this standard has not been met.
✗ Is this project something I’m familiar with and have been doing for a while?	While the challenge of poor quality urine sample collection is clear, services have not yet adapted to change the way it is tackled.
✓ Has it got a good a chance of working?	The value to patients and services has been demonstrated in modelling and trials conducted to date.
✓ Has the patient voice been considered?	Yes – data suggests new forms of urine testing can improve patient experience.
✓ Does it support the Cancer Strategy Priorities?	Yes – faster testing can help meet the 62 day target and lead to earlier diagnosis of cancer.
✓ Is it financially feasible?	Yes – there can be a cost saving of around 10%.

Challenge 4: Improving the Effectiveness of Cancer Multi-Disciplinary Teams

It is often the case that existing cultures within the NHS can be reticent to embrace change, with best practice often seen through the prism of 'doing yesterday better'. This presents a challenge in that new, potentially disruptive ways of working are likely to be rejected if they go against ingrained practice.

With the NHS currently being a highly cost and time-pressured environment, the collation and use of data to demonstrate tangible, measurable savings to budget and workloads is an excellent means to demonstrate the limitations of existing practice and make a case for cultural change. Cancer Research UK³ has conducted some recent research which uses data to suggest how multi-disciplinary teams can be improved in cancer services.

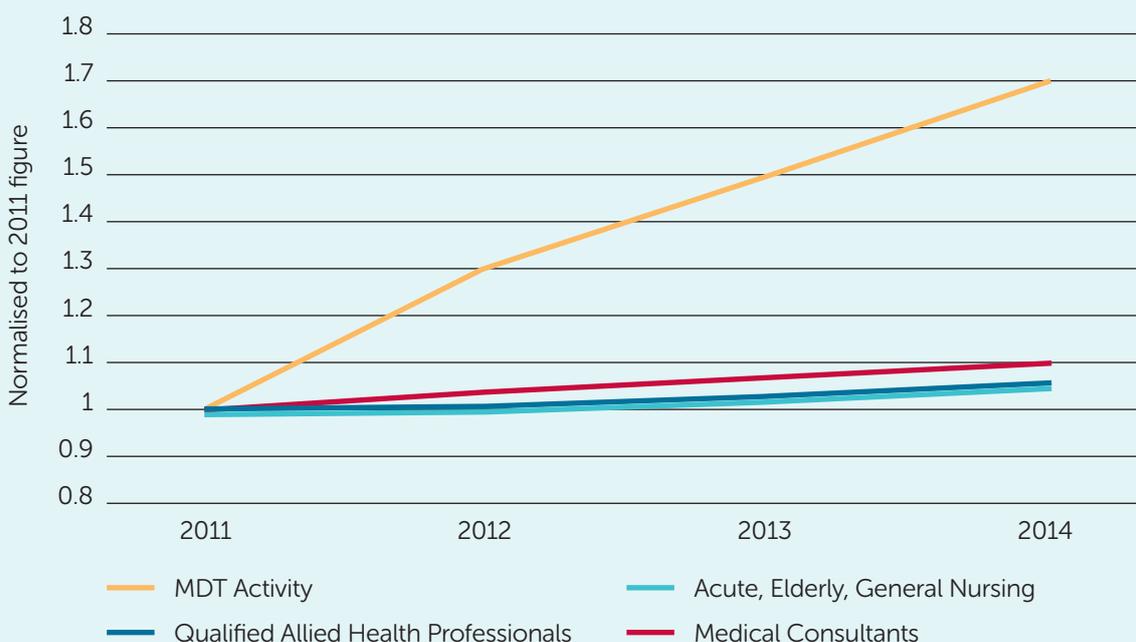
Case Study Name: Cancer Research UK (CRUK): Improving the Effectiveness of Multi-Disciplinary Team Meetings in Cancer Services

Overview: Whilst multi-disciplinary teams (MDTs) are considered to be the gold standard of cancer services, in terms of improving standards of care and access to treatment, there is now recognition, as highlighted in the **Cancer Strategy**, that MDT working should be refreshed.^{xxi}

Research undertaken by CRUK echoes this, finding that whilst the number and complexity of cases discussed at MDTs have increased, new ways of working would improve their effectiveness.^{xxii}

Growth in Number of MDT Discussions and Whole Time Equivalent (WTE) of Staffing Groups in England, Normalised Relative to 2011 Levels

Graphic developed by Cancer Research UK



³Cancer Research UK is one of the UK's leading charities, supporting cancer patients and services.

Activity: CRUK undertook research, which identified that:

- The number of cancer patient discussions in MDTs has increased by approximately 20 per cent each year since 2011. This has not been matched by increased staff numbers.
- Meetings are incredibly resource-intensive and often involve 15 or more staff attending weekly meetings that can each last several hours.
- The mean length of a patient discussion was 3.2 minutes. Almost half of all patient discussions (48%) lasted two minutes or less.
- Only 15% of discussions contained information that did not directly relate to the patient's tumour.
- The total cost of MDT meetings in England increased from £88 million in 2011/12 to £159 million in 2014/15. This is a substantial cost increase at a time when the health service has been required to find savings.^{xxii}

By identifying these issues, CRUK was able to make a number of recommendations (based on evidence), including:

1. Agreed 'protocolised pathways' for standard treatment and recommendations should be applied to tumour types – these should be implemented by Cancer Alliances based on recommendations developed at a national level.
2. For tumour types where this approach has been developed, a 'pre-MDT triage meeting' would identify patients who can follow the protocolised pathway and reduce discussions at the MDT.
3. National requirements for individual minimum attendance should be reviewed and amended where necessary, with an emphasis on ensuring all required specialities are present at a meeting.
4. MDTs should focus their discussions around a new pro-forma document containing all relevant information to that patient's case; this would include everything from diagnosis information to the patient's personal preferences and a holistic needs assessment.
5. MDTs should use a database or pro-forma to enable documentation of recommendations in real time – ideally, this should be projected so that it is visible to all MDT members.
6. Each MDT should ensure they have a mortality and morbidity process to ensure adverse outcomes are discussed by the whole MDT and learned from, rather than discussed in silos.^{xxii}

Outcomes:

- Research demonstrates the clear need for reform and proposes solutions. NHS England is now considering the recommendations and how to take them forward. Cancer Alliances have also begun to consider how changes can be implemented on a local level.
- The adoption of requirements regarding speciality attendance (rather than minimum individual attendance) has been modelled at a Foundation Trust in the North of England, which found 129 clinical days could be saved per year, without compromising care.
- A trial in the Midlands found that a pro-forma document can reduce variation in care and help hospitals meet the 62-day diagnosis to treatment targets.^{xxii}

Does this Case Study Meet Best Practice Criteria?

Best Practice Criteria		Notes
✓	Can this be delivered within 9 – 12 months?	MDTs meet regularly and operational changes could be rapidly implemented.
✓	Is it scalable and replicable?	Protocolised pathway approaches can be shared across tumour types and Trusts.
✓	Is this idea new and innovative?	Yes
✗	Is this project something I'm familiar with and have been doing for a while?	Although MDTs are a familiar part of the cancer care landscape, these changes would fundamentally reshape how they operate in order to deliver more effective care to patients.
✓	Has it got a good a chance of working?	Changes would be welcomed by clinicians, as evidenced by the report's survey of MDT attendees, and it has been demonstrated that considerable capacity could be freed in each trust that adopts these changes, allowing for more time to be dedicated to patient care.
✓	Has the patient voice been considered?	The recommendations made by Cancer Research UK focus on ensuring a patients needs are discussed and evaluated in more detail when required.
✓	Does it support the Cancer Strategy Priorities?	The Cancer Strategy Priority Area "Investing in high quality, modern services" includes a focus on ensuring cancer workforce capacity needs are being met.
✓	Is it financially feasible?	Revisions to MDT meetings would not require major set up costs as the teams already meet regularly and could lead to better use of resources via better use of staff capacity.

Challenge 5: An Embedded 'Silo' Approach

Another cultural barrier is the 'siloed' approach often taken by the NHS. Cancer Alliances have been introduced as an acknowledgment of the need for local clinical leaders and managers to work together to improve services. The below case study highlights how this cultural shift towards collaborative working across Trusts can lead to the implementation of best practice and improved outcomes.

Case Study Name: London Cancer/UCLH Cancer Collaborative: Radical Prostate Cancer and Bladder Cancer Surgery^{vi}

Overview: The London Cancer/UCLH Cancer Collaborative brings together healthcare organisations across north central and north east London, as well as west Essex. Prior to pathway redesign, care for five Urology tumour types was provided by two cancer networks comprising 11 trusts and 14 hospitals across the region covered. The service and pathway re-design was led by John Hines, Urology Pathway Director for London Cancer and consultant urological surgeon.^{vi}

This new approach has allowed far-reaching pathway redesign and novel MDT functioning across a large system in response to changing treatment guidelines and emerging robotic surgical technology. It has also led to improved outcomes and experiences for patients, while making services run more efficiently across the whole Collaborative.^{vi}

Activity: Poor outcomes, combined with new guidelines and working practices, along with the new opportunities for joint working, created a drive to evolve the services provided by hospitals in north east and north central London. 'London Cancer' integrated care system, part of UCL Partners, an Academic Science Health Partnership, was therefore created. The resulting service re-design of major surgery for prostate and bladder cancer was based on the proven concept that clinical outcomes are better in large volume centres. To allow such a large-volume single-site centre for major prostate and bladder cancer to be accommodated, the radical decision was taken to split the surgical treatment of renal cancer to another large-volume, single-site centre, in a different trust. Local diagnosis and other treatments, that are not dependent on large-volume activity are still provided locally. This innovation is now being copied in other major centres in the UK. There has been a movement of surgeons and CNSs across the system to work in the new pelvic cancer centre, at University College Hospital.^{vi}

The service redesign demanded MDT redesign and an innovative approach was required. A single specialist MDT (SMDT) for pelvic cancer, the approved NHS model for a single pelvic cancer centre, would have been too large to function efficiently so three 'parallel-running' SMDTs spread geographically across the system have been developed.^{vi}

Timed diagnostic pathways were introduced in both prostate and bladder cancer to meet the 62-day

treatment target. The three specialist MDTs work in parallel using the same guidelines and due to the collaborative nature of the pathway, surgeons can also work across sites and attend each of the three MDTs as required. Patients receiving care from any of the hospitals involved can also be referred directly to the new pelvic specialist centre.^{vi}

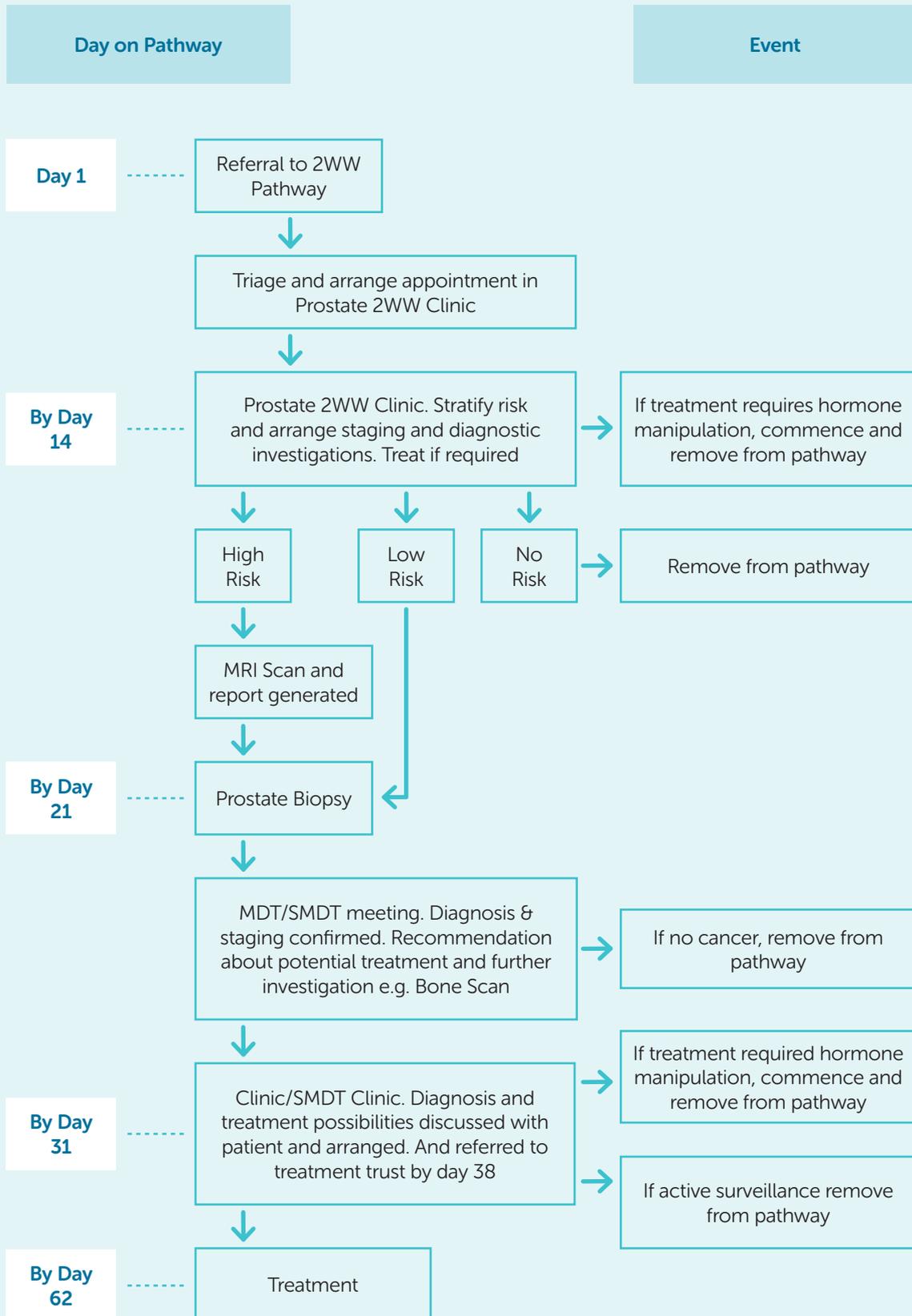
The learnings from an audit of services at one of the three sites are also being used to adapt and improve care at the other two. This collaborative delivery of services has also allowed the introduction of Enhanced Recovery Packages for patients with bladder or prostate cancer, while freeing up bed capacity and making budget available for new technology to deliver robot-assisted surgery. Patient feedback, including data from focus groups, is being used to identify areas for further improvement in future and to judge the success of existing reforms.^{vi}

Outcomes: There are a number of positive outcomes resulting from this collaborative working:^{vi}

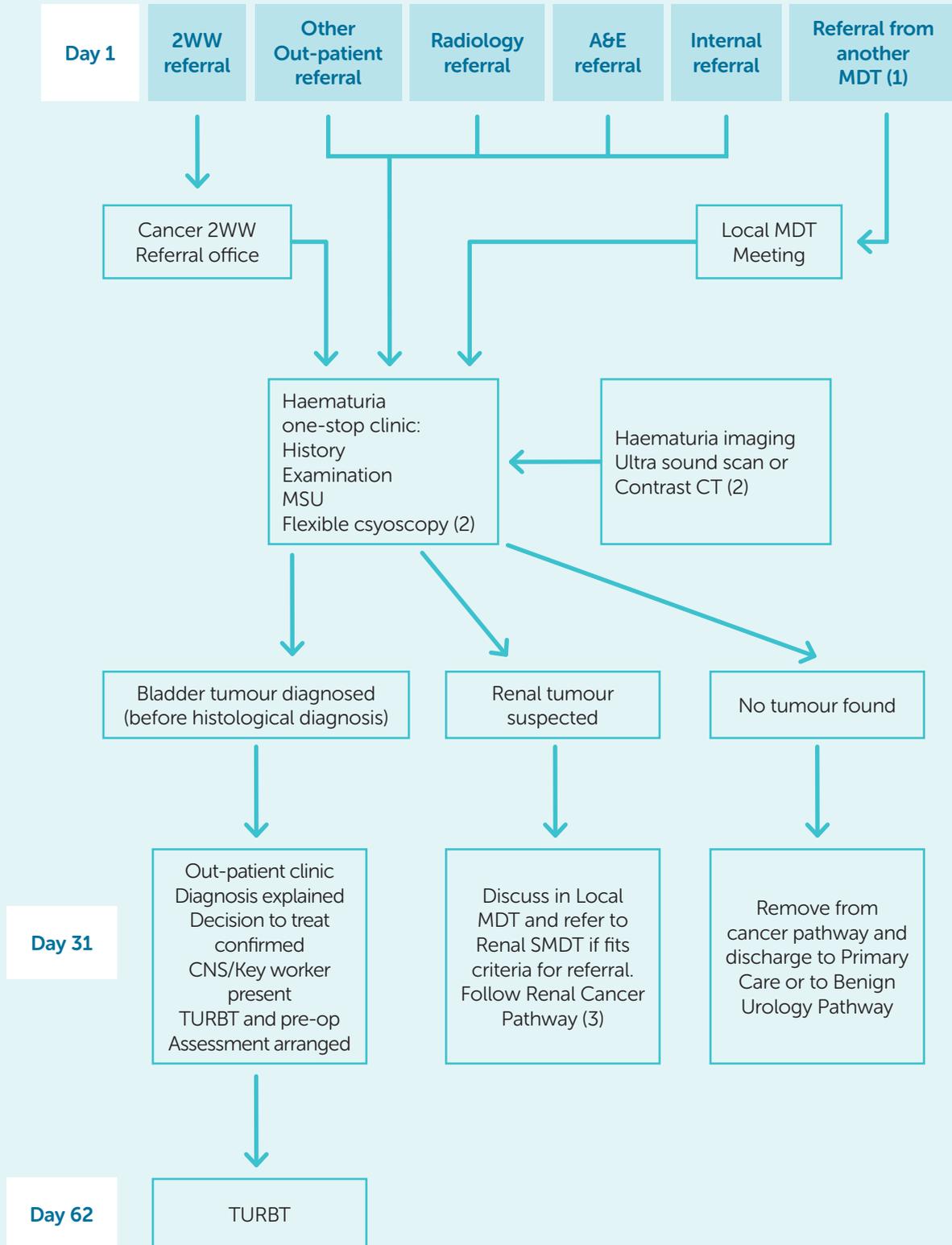
- Surgical outcomes have improved across a number of different measures.
- The Collaborative became the first network in England to introduce pre-biopsy MRI scans for all prostate cancer patients.
- For bladder cancer, the Enhanced Recovery Package has reduced the median length of hospital stay for patients from 12 to 7 days.
- The creation of a specialist centre has also improved bed flow across the Collaborative.
- The number of patients who have the opportunity to discuss access to clinical trials as part of these specialist services is also far higher than the national average.
- Patient experience and feedback is universally positive.
- The 2015 Peer review of cancer services ranked UCLH Bladder and Prostate MDT highest in country.^{vi}

The opportunity for collaborative working has overcome an inherent cultural and organisational challenge, with staff now able to work across hospitals and to refer patients to specialists in other Trusts. With Cancer Alliances being introduced across England, there is now the opportunity to deliver similar joint working projects nationally.^{vi}

London Cancer Prostate Cancer Diagnostic Pathway



London Cancer Bladder Cancer Skeleton Diagnostic Pathway



Does this Case Study Meet Best Practice Criteria?

Best Practice Criteria		Notes
✓	Can this be delivered within 9 – 12 months?	Setting up Collaborative projects can be a long-term goal – the UCLH Collaborative has a three year strategy. However, this case study shows that additional improvements can be implemented quickly based on feedback and other factors once the Collaborative is in place.
✓	Is it scalable and replicable?	Similar pathway redesign could be introduced collaboratively across other tumour types based on this model. However, different geographies will have their own service redesign needs and challenges.
✓	Is this idea new and innovative?	Yes
✓	Is this project something I'm familiar with and have been doing for a while?	The opportunity presented by the introduction of Cancer Alliances allows for innovative new service redesign opportunities.
✓	Has it got a good a chance of working?	The UCLH Collaborative example suggests there are opportunities to use this approach to deliver improvements in resource allocation across Trusts as well as making gains in patient outcomes and experience.
✗	Has the patient voice been considered?	This is a commissioner-led service redesign. However, feedback has been universally positive.
✓	Does it support the Cancer Strategy Priorities?	This is an early example of how the Vanguard programme and the Cancer Alliances can deliver reforms.
✓	Is it financially feasible?	Cost savings are being achieved via shorter hospital stays and by streamlining the number of teams delivering care.

Overcoming Adversity

As the Bevan Commission criteria allude to, not all attempts at best practice will necessarily succeed on the first attempt. It is important, however, that the NHS can learn from these in order to innovate and improve.

This is evidenced by the below example of a bowel cancer screening programme initiative. The National Bowel Screening Programme was introduced over 10 years ago, but uptake has always been significantly less than the other two national cancer screening programmes (cervical and breast). Currently, the national uptake rate is 57% and is much lower in areas of greater deprivation.

It is therefore important for the NHS, Public Health England, CCGs, charities and primary care to work together to find ways to increase uptake. One innovative way that this is happening in Greater Manchester is Beating Bowel Cancer's Community Bowel Screening Volunteers Project.

Case Study Name: Beating Bowel Cancer's 'Community Bowel Screening Volunteers Project'

Overview: More than 40,000 people are diagnosed with bowel cancer each year in the UK. As of 2015, bowel cancer was also responsible for more than 15,000 deaths annually.^{xxiii}

A national bowel cancer screening programme was established to improve early diagnosis and lead to more effective treatment that is less detrimental to a patient's quality of life. Following poor uptake of this, charities developed a number of initiatives to boost the amount of people taking up the opportunity to receive screening.

Activity: In Greater Manchester, Beating Bowel Cancer has trained volunteers to go in to GP practices and telephone non-responders who were recently invited for screening. The aim is for volunteers to have informative conversations about the importance of bowel screening in order to drive uptake. If the conversation is positive, a bowel cancer screening kit can then be sent out.^{xxiv}

In Liverpool, PHE has taken another innovative approach. Working with the Merseyside and Cheshire Fire and Rescue Services, PHE has trained firefighters to deliver certain medical advice when visiting the homes of vulnerable people over the age of 65. This includes information on the importance of bowel cancer screening. Following these visits, the Fire Service can also help to ensure the correct screening kits are sent to those visited.^{xxv}

Outcomes: In both cases, a revised approach to bowel cancer screening has resulted in increased uptake of the services:

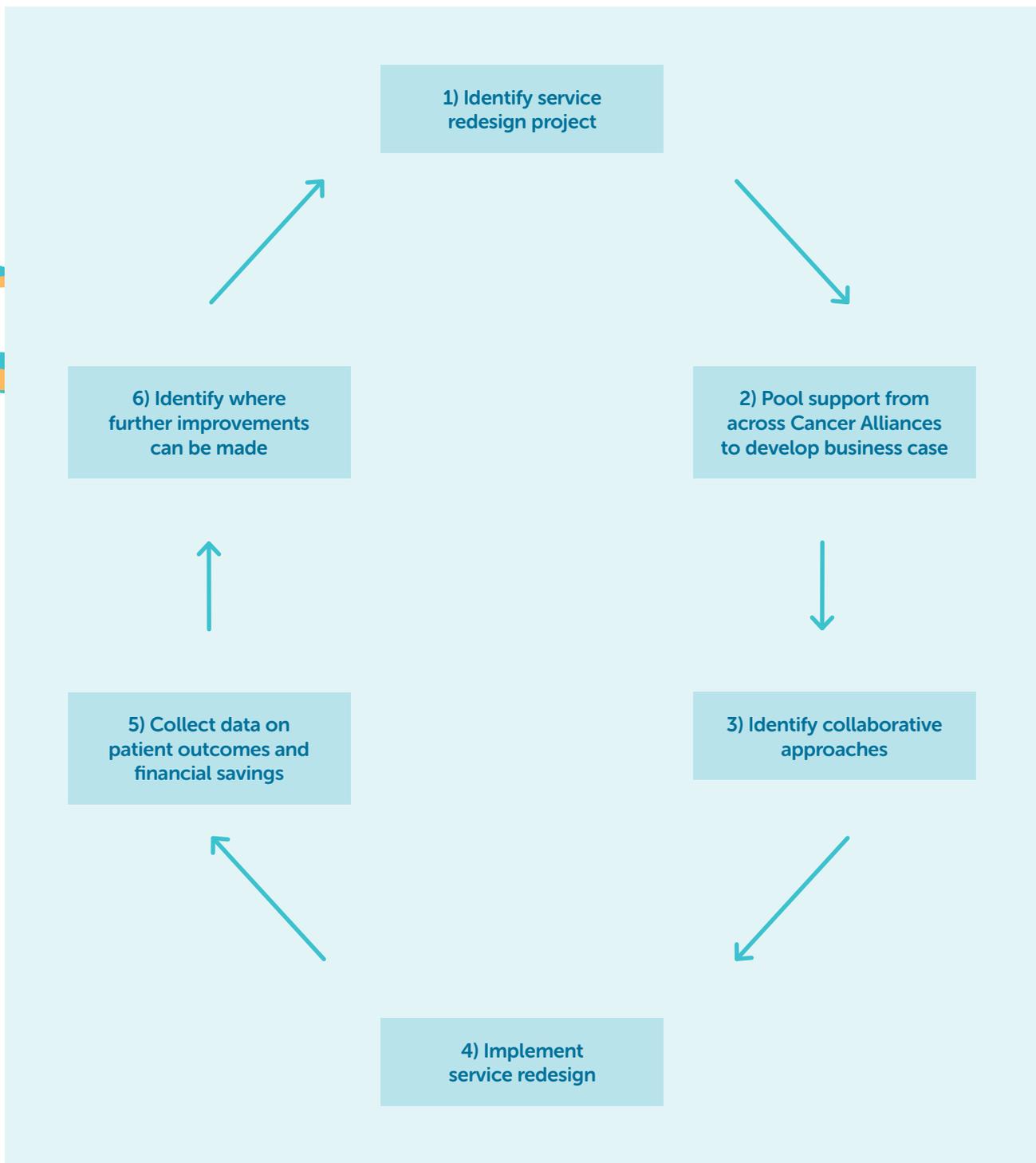
- In Manchester, more than 70% of those spoken to gave their consent to be sent a new screening kit with the intention of completing it. Of those 70%, at least 33% have gone on to complete the kit, increasing screening rates in participating GP practices by an average of 6.5%.^{xxiv}
- Of those who used a home screening kit as a result of the project, four had abnormal screening results and two of these people had suspicious, potentially pre-cancerous polyps removed. Beating Bowel Cancer expects that continuing the project with just its current, limited, resources alone would lead to three cases of cancer being diagnosed and treated early each year.^{xxiv}
- Cheshire Fire and Rescue carried out almost 16,000 home visits between February and June 2017, which resulted in 1,098 bowel cancer referrals. In Merseyside, the visits lead to around 120 referrals in a particular month. This service has been recognised and awarded a Healthcare Transformation Award.^{xxv}
- As well as the survival benefits involved, treating bowel cancer patients at an early stage will also save the NHS money in the long term. The cost of treating a stage 4 bowel cancer patient is estimated at £12,519, whereas the cost of treating a stage 1 patient is just £3,373.^{xxvi}

Does this Case Study Meet Best Practice Criteria?

Best Practice Criteria		Notes
✓	Can this be delivered within 9 – 12 months?	Both case studies have demonstrated measurable improvements within a period of months.
✓	Is it scalable and replicable?	Similar changes could be made to improve other screening programmes for cancer. However, it is the overall approach that is most scalable – developing and continually redesigning services to achieve best practice and improved outcomes even if initial results are discouraging.
✓	Is this idea new and innovative?	Even when services have been redesigned, Cancer Alliance and others must continue to look for innovative ways to improve. This is especially true when the service initially underperforms expectations.
✓	Has it got a good a chance of working?	Reassessing an approach based on insight and improved communication with patients is likely to see increased success.
✓	Has the patient voice been considered?	The approach taken by bowel Cancer UK aims to use feedback from service users about what works and what doesn't and to rectify the way care is delivered as a result.
✓	Does it support the Cancer Strategy Priorities?	Early diagnosis is a key priority for NHS England.
✓	Is it financially feasible?	The cost saving for every bowel cancer patient diagnosed at stage 1 rather than stage 4 is around £9,000.

Implementing Best Practice: A Step-by-Step Plan for Cancer Alliances

The key learnings from the case studies above demonstrate a clear step-by-step guide for how Cancer Alliances should identify and implement best practice across services. Each step is considered in more detail below.



Step 1: Identifying Service Redesign Projects

- There are a number of ways to identify service design projects, including through research papers, reviews of existing practice, feedback from patients, or by ideas generated from within the service by clinicians and other staff.
- These projects could be evaluated by Cancer Alliances using the Best Practice Criteria outlined in this report, based on the Bevan Commission.

Step 2: Develop a Business Case with Cancer Alliance Support

- Project plans, proposals and business cases often need to be developed to justify the redesign of services. However, clinicians may not always have the skills or capacity to write them.
- Cancer Alliances should provide dedicated administrative staff time to help with the development of these proposals once it has become clear that the best practice criteria have been met.
- This approach should be collaborative: Cancer Alliances should encourage administrative staff to pool their time across hospitals and Trusts within the Network in order to provide the capacity required to develop best practice proposals.
- Where possible, Alliances should also encourage staff to develop the necessary skills to be able to create business plans themselves in future as part of their training plans.

Step 3: Identifying Collaborative Approaches

- Many best practice examples may require collaborative working in order to be a success.
- As business plans are developed, opportunities to work collaboratively should be identified. This may include working with external partners, such as charities and patient groups.
- Cancer Alliances should also explore whether they can implement best practice more effectively by drawing in support from multiple Trusts across the area it manages.

Step 4: Implementing Service Redesign

- When deciding if a Trust can implement service redesign plans, consideration must be paid not only to the upfront cost of redesigning services but also the potential financial savings generated by the project.
- Cancer Alliances should plan budgets to allow for this flexibility where possible.

Step 5: Data Collection

- Cancer Alliances must require all service redesign projects to build in sufficient steps to collect data on their impact.
- This should include data on patient outcomes, patient feedback and patient experience, and an assessment of the cost impact of the service redesign.
- Where possible, this data should be developed in a publishable format (in academic journals and elsewhere) in order for best practice to be more widely disseminated across other geographies.
- Individual Cancer Alliances should also actively explore ways to collaborate with others across the network in order to share examples of best practice and to learn from other services.

Step 6: Feedback: Identify Further Improvements

- Using collected outcomes data, as well as feedback from patients and staff, Cancer Alliances should work with the staff leading the service redesign project to identify limitations and areas for further improvement.
- This should not be seen as reasons to cancel or reverse service redesign, but rather as areas for improvement.
- This feedback should then be used for further service redesign in order to overcome the limitations and to continue to improve outcomes.

Appendix

Business Case Template

Purpose of this document

This guide and template business case complements this All.Can report. It was recognised by the All.Can Working Group that clinicians in cancer services will have considerable insight into how best to improve the cancer care pathway, however can sometimes lack the capacity, time and resource to create the business case necessary to introduce service redesign. The purpose of this document is therefore to provide a pro-forma template that will help to identify and outline the desired outcomes of implementing a cancer service redesign project, and the potential costs and benefits accrued in delivering it.

This document should be compiled after an informal discussion has been had with colleagues, including relevant Clinical Directors and Business Managers to assess the likelihood of success, and the proposal criteria that will be used by managers in the initial reviewing of business cases after submission.

Business Case:

[insert service title, e.g. 'A Fast Track Surgery Pathway for Pancreatic Cancer']

Action requested:

This paper is provided for approval at the [enter name of group/board]

Contents:

Section

- 1 Cancer in the UK
- 2 Executive summary
- 3 Background and case for change
- 4 Current service
- 5 Future service
- 6 Options analysis
- 7 Financial appraisal
- 8 Risks and issues
- 9 Funding source
- 10 Timescales
- 11 Key performance indicators
- 12 Conclusion and recommendations
- 13 Appendix

N.B. Advisory text on how to complete this business case is provided in blue throughout. Please delete prior to submission.

Boxed out content checklists are provided at the bottom of each section. These should also be deleted prior to submission.

1. Cancer in the UK

This section provides a background to the wider policy and environmental issues impacting the service and business case, and reinforces the case for change.

Cancer is a major health issue in the UK, affecting more than 350,000 people and causing more than 160,000 deaths a year.ⁱ One in two people in Britain born after 1960 can now expect to receive a cancer diagnosis during their lifetime, despite more than 40% of cases being deemed preventable.ⁱ As a result, cancer is also a major cost to both the NHS and the local economy.ⁱⁱ Within the NHS, there is considerable regional variation and within our Alliance **[insert relevant local data here. This may include statistics relating to incidence of the relevant type of cancer compared to national averages]***.

In the 2017 Cancer Strategy update, it was highlighted that earlier and faster diagnosis and equity of access to treatment and care are central to the National Cancer Programme and transformation of services they want to achieve by 2020/21.^{xxvii} Similarly, the stated aims of this Cancer Alliance are as follows:

[Insert aims and objectives]

Locally, as the number of **[insert speciality]** cancer incidences increases, a significant change in approach is required to achieve the deliverables set out both by our Alliance and NHS England. Across the NHS, there are examples of best practice care, the learnings and improvements from which can be reflected in our own **[Trust / Alliance]** to improve performance, increase efficiency and ultimately, improve patient care.

NHS England recognises that the attainment of the 62-day referral-to-treatment standard will 'depend on doing things differently so that we can use precious resources wisely'.^{xxviii} As a Cancer Alliance our role is to bring clinical leaders and teams together to transform diagnosis and treatment in our local area in order to achieve this, and other targets. Alliances all over the country are testing new models of rapid diagnosis and reassessment which are scalable and can be rolled-out more widely to improve patient outcomes.

2. Executive summary

The executive summary should be written last, and provides an overview of all sections detailed in the business case template. It concludes with a request for a decision and/or investment.

The **[insert team]** is proposing a new pathway that will **[insert overarching aim and objective]**. The current service **[insert information about inefficiencies of existing service]**.

Having considered the risks and benefits of all options, including that of making no change, we recommend the following proposal which will embed the pathway in standard practice across the Alliance by **[insert timeline]**. An upfront investment of **[insert cost]** will deliver **[insert key performance indicators]** in the **[first/second year]**. It will also realise a cost saving of **[insert cost saving]** by **[insert date]**.

The budget required to deliver this revised service has been identified from **[insert details of financial source]**.

This investment will allow this Alliance to **[insert how this proposal aligns with NHS England and Cancer Alliance objectives]**

Checklist (delete after completion):

- Short summary for each section of the business case
- No more than 1/10 the length of the main business case
- Simple, declarative sentence for each of the main points
- Conveys: Purpose; message; and key recommendations

* Incidence data can be found at: <http://www.cancerresearchuk.org/cancer-info/cancerstats/local-cancer-statistics>

3. Background and case for change

This section covers the purpose of the business case, highlighting the key method of change and projected results, as well as the programmes alignment with the wider Cancer Alliance strategic objectives and NHS targets. For example:

As outlined in section 1, there is a clear impetus for change within cancer services in the NHS. It is important for our pathways to align with the best practice models of care that have shown increased efficiency and improved patient outcomes.

In this vein, the team has taken inspiration from [insert best practice example and outcomes]

We will:

[Insert overview of:

- Objective, requirements and outcomes.
- Reason for business case.
- Alignment with Cancer Alliance delivery plans, e.g. collaborative working, place-based approaches to improving cancer outcomes, personalised care.
- Alignment with National Cancer Strategy objectives: early diagnosis, fast diagnosis and equity of access to treatment and care.
- Related initiatives or previously successful schemes.]

Checklist (delete after completion):

- Concerns raised about existing service and provision of care that led to this proposal.
- Impact areas driving change, e.g. increased demand, need for greater efficiency, improving patient access to care, improving quality of care.
- Conveys alignment with, and achieves the priorities of, the National Cancer Programme and local Cancer Alliance strategic intentions.

4. Current service

This section looks at the current performance measures and requirements of a service, with regards to staff levels, equipment, unmet need, regional variation, collaborative working and skills or relevant training. For example:

[Insert Trust] sees [insert number] new [insert condition] referrals over the course of a year. Following the initial consultation, it will take [insert number of weeks] for a patient to receive a diagnosis / start treatment. The current standard treatment pathway in [insert Trust] is as follows: [insert treatment pathway].

The annual cost to this Alliance of treatment and follow up within this speciality is [insert cost].

The Quality Standard for this treatment pathway is [insert QS]. Currently, we [insert current status of meeting these Quality Standards].

Throughout a patient's treatment, they will require on average [insert number] staff hours, and [insert bed hours]. Treatment requires input from [insert HCPs involved in treatment pathway]

Year on year, the department is seeing an increase of [insert percentage increase of patient admissions]. This is [in line with/more than/less than] the UK as a whole.

The NHS has set a target of a 62-day referral to treatment standard for suspected cancer. The current waiting time on this pathway is [insert waiting time].

Checklist (delete after completion):

- Current performance measures.
- Description of existing service with regards to: staff, equipment, patient unmet need, regional variation, collaborative working, skills/training.
- Deficiencies in current pathway when compared to wider NHS / Cancer Alliance strategic intentions.

5. Future service

The future service section will address the performance measures highlighted in the above 'current service' chapter. It will address the benefits of the new proposed pathway in relation to the existing service, with the stated aim of closing the gap between Alliance and NHS England targets, (62-referral time, early diagnosis) and current practice.

	Current service inefficiencies / key issues	Benefits of proposed service
Finance	E.g.: <ul style="list-style-type: none"> • [#] staff hours wasted at unnecessary MDT meetings • [#] additional surgeries required due to delays in treatment 	
Quality	E.g.: <ul style="list-style-type: none"> • Inequality in patient care across Trusts • Significant deterioration in patient involvement in treatment choices • [#] patients able to access cancer support services 	
Integration	E.g.: <ul style="list-style-type: none"> • Referral of suspected cancer patients from A&E/ opticians/other departments • Barriers of accessing treatment at an early stage 	

Checklist (delete after completion):

- Alignment with NHS England / Cancer Alliance strategic intentions.
- Recognition of flaws within the existing service, and how the proposed new pathway/ intervention will address these.

6. Options analysis

The options analysis presents the benefits and limitations of all possibilities, to demonstrate that all choices for improving the service have been considered. The analysis should contain between three and five options including a 'do nothing' or a 'do minimum', as this is the benchmark against which other objections will be judged.

The options should be described in detail, including, for example: costs (e.g. equipment, staffing, training); space requirements; impact on performance and financial indicators; impact on wider hospital systems, e.g. IT; and projected timelines where available. If necessary, this could be done in two stages – a broad outline of a wide range of options, followed by a detailed examination of the three most viable possibilities.

The benefits and limitations should be considered (where necessary) for patients; primary care; secondary care; acute care; providers; and commissioners.

The following options for offering a [insert pathway / intervention] have been considered:

Option	Description	Benefits	Limitations
Do nothing		E.g.: <ul style="list-style-type: none"> In some areas, good models of care in both primary and secondary pathways 	E.g.: <ul style="list-style-type: none"> Significant variation in follow up time Unlikely to meet 62-referral target Requires significant year-on-year costs to cover locum fees Does not address increasing issue of bed blocking
Involvement of third party (e.g. charity or external provider)		E.g.: <ul style="list-style-type: none"> No investment needed from primary care 	E.g.: <ul style="list-style-type: none"> May not be popular with patients
[insert alternative option]			
[insert alternative option]			
[insert recommended option]			

Analysis of these options shows that [insert option] is the preferred option, as:

- [insert overview of benefits of preferred option when compared to others considered in table, e.g.:]
 - Cost per patient is significantly reduced
 - Although requiring an investment upfront, this will be recouped within a year and savings will continue year-on-year
 - It offers a high level of patient satisfaction
 - It will improve the Trust/Alliances' 62-day referral figures
 - It offers increased streamlining of the service thereby improving efficiency

Checklist (delete after completion):

- Most viable options discussed, including 'do nothing' and consideration of charity and external provider opportunities if applicable.
- Each option listed in sufficient detail for the benefits and costs to be understood and assessed in a financial and risk analysis.
- Each option to have considered: costs; workload; staffing consequences; site and facilities; impact on performance indicators; impact on financial performance; impact on hospital systems; impact on patients; impact on Cancer Alliance strategic intentions; compliance with NICE guidelines and Quality Standards; impact on local commissioning.
- Preferred option stated.

7. Financial appraisal

The appraisal outlines the financial impact of the recommended option, outlining the cost assumptions and predicted change. This section can be highly technical and it is advisable to liaise with finance and other relevant departments where appropriate.

The objective of this section is to demonstrate that all the financial benefits and consequences of a proposal have been identified and accurately reflected.

The financial assumptions of this proposal are as follows:

Sector	Description	Cost
Upfront costs Recurrent costs E.g.:		
<ul style="list-style-type: none">• Cost per bed per day• Secondary care follow up appointment• Primary led follow up care• Blood tests• [x] surgery• IT changes• Admin support• Self-care kits• Equipment rental		

The non-financial assumptions of this proposal are as follows: E.g.:

- Volunteers will reach [insert number] of patients, of whom [x%] will request a self-test kit
- [insert number] of extra staff hours will be required / saved
- Bed capacity will increase / decrease by [insert % or number of beds]
- [x%] of patients are discharged after [insert number] days
- Equipment rental is in line with current external tender agreements

The resource requirements for the first year are as follows:

Resource requirement	Capital investment (£)	Difference in running cost from existing pathway (£)	Year 1 cost/saving (£)
Total			£

The financial savings per year are illustrated as follows:

Sector	Year 1 (£)	Year 2 (£)	Year 3 (£)	Year 4 (£)	Year 5 (£)	Total (£)
E.g.: patient costs, staff costs						

Supporting data from similar best practice initiatives:

[Insert applicable data]

Checklist (delete after completion):

- All financial costs – upfront and recurrent – detailed.
- All assumptions of costs – both financial and non-financial – detailed
- Acknowledgement of how staff, premises and other assets may be affected if the current service is changed. To include: management of staff; training; equipment rental; external tenders; patient satisfaction; IT costs; bed capacity.
- Financial investment and savings demonstrated over a period of five years

8. Risks and issues

The key business risks associated with the recommended option should be summarised within this section, particularly those which may impact on the financial projections – both costs and benefits. The risks are most likely to arise from the assumptions stated in the above financial appraisal; these should be considered in view of the strengths, weaknesses, opportunities and threats that external factors may pose to them. The risks should be presented by probability, impact and final risk score on a scale of 1-5.

This section also provides an opportunity to offer mitigation for the risks.

	Risk	1 = low, 5 = high			Mitigation
		Probability (P)	Impact (I)	Risk score (P×I)	
1	Low engagement from partners				
2	Under-skilled workforce				
3	Patient safety				
4	Misdiagnosis				
5	Increased rate of admissions				
6	Unexpected side effects				
7	Impact on prescribing budget				
8	Staff sickness / resignation				
9	Lack of funding after initial period				
10	Delayed implementation				
11	Impact on equality assessment				

An evaluation of the risks and issues demonstrate that the impact of not changing the existing service is more detrimental than the risks involved in implementing the proposed option.

Checklist (delete after completion):

- Risks identified in options analysis are evaluated and mitigated
- Wider issues, including workforce requirements and future organisational changes are considered.
- Risk of maintaining the current service is communicated in relation to the risk of implementing change.
- Examples of challenges – and subsequent solutions – faced by similar programmes shared if applicable.

9. Funding source

State the location for the financial investment identified in section 6, be it required, known or suggested. This needs to cover capital costs and recurrent costs. An indication should be given of the certainty or otherwise of the funding being available when required.

Funding sources could include:

- Existing departmental budget (e.g. for ongoing staff costs)
- Cancer Alliance
- Charity grants
- Cancer Vanguard

Checklist (delete after completion):

- All costs identified in section 6 accounted for.

10. Timescales

The proposed timescale should be provided, including major milestones within the project, for example recruitment of patients / staff, clinics opening, major dependencies and procurement arrangements.

When relevant, the timescale should also state when the investment should be reviewed, and the wider Cancer Alliance/STP timelines.

Timelines for the proposed activity are as follows:

E.g.: Mobilisation from approval to operational	[insert time in weeks]
Target state date	[insert date]
Review and evaluation	[insert dates]
Cost saving realised	[insert date]
62-day referral target achieved	[insert date]

Checklist (delete after completion):

- Period of time over which the service will achieve the return on investment previously detailed.

11. Key performance indicators

Within this section, key performance indicators (KPIs) should be set that allows the programme to be evaluated at phases set out within the above timeline. The KPIs should reflect both the cost saving identified in the financial analysis, and the objectives set out at the start of the business case.

The KPIs set should also reflect those of the Cancer Alliance, Cancer Strategy and Five Year Forward View, to demonstrate an ongoing adherence to wider policy objectives and NHS priorities.

Key performance indicator (KPI)	Date of review

Checklist (delete after completion):

- Key deliverables stated.
- Alignment with wider Five Year Forward View / Cancer Strategy / Cancer Alliance KPIs

12. Conclusion and recommendations

A short conclusion should outline the recommended option and review the risks and benefits that have been considered in the formation of the proposal. It should refer to the stated timeline and request a decision.

It is clear from the case outlined above that [insert proposal title] is the preferred option. The introduction of [insert pathway / new model of care] will improve the efficiency and effectiveness of [insert applicable KPI]. It will also improve patient satisfaction and align this service with the stated aims of our Cancer Alliance.

The recommendation is cost effective, saving [insert cost saving] over [insert number of years] and will release significant [e.g. staff time, bed space, capacity] for the hospital. It meets the needs and requirements of patients and is in line with the Cancer Alliance's strategic objectives.

The following clinicians and stakeholders have expressed support for this proposal:

- [insert list of clinicians, budget holders, NHS officials, patient groups]

13. Appendix

Insert relevant supporting information, e.g. workload assessments, financial calculations / evidence, case studies, equality impact assessments.

References

- i. Cancer Research UK, 2014. 'Cancer Statistics for the UK'. Available at: <http://www.cancerresearchuk.org/health-professional/cancer-statistics-for-the-uk> [Last accessed: April 2018]
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- iii. NHS England, Guidance for Cancer Alliances, available here: <https://www.england.nhs.uk/wp-content/uploads/2017/02/cancer-alliance-guidance.pdf> [Last accessed: April 2018]
- iv. Independent Cancer Taskforce, Achieving World-Class Cancer Outcomes: A Strategy For England 2015-2020, available here: http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf [Last accessed: April 2018]
- v. Roberts et al, A reduced time to surgery within a 'fast track' pathway for periampullary malignancy is associated with an increased rate of pancreatoduodenectomy, available here: <https://www.ncbi.nlm.nih.gov/pubmed/28566239> [Last accessed: April 2018]
- vi. UCLH Case Study
- vii. Forte Medical, Gold Standard Specimen Collection, July 2017
- viii. Breast Cancer Now, 2017. 'What is the Service Pledge?' Available at: <http://breastcancer.org/get-involved/campaign-with-us/improving-services/what-is-the-service-pledge> [Last accessed: April 2018]
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