



Evaluation of the Macmillan Cancer Improvement Partnership

Phase 3 Final Report: Executive
Summary

26 February 2018

Evaluation of the Macmillan Cancer Improvement Partnership

Phase 3 Final Report: Executive Summary

A report submitted by [ICF Consulting Limited](#)

Date: 26 February 2018

Job Number 30301169

[Lucy Loveless](#)

[ICF Consulting Limited](#)

Watling House

33 Cannon Street

London

EC4M 5SB

T +44 (0)20 3096 4800

F +44 (0)20 3368 6960

www.icf.com



Document Control

Document Title	Evaluation of the Macmillan Cancer Improvement Partnership
Job No.	30301169
Prepared by	Kelly Singh and Lucy Loveless
Checked by	Lucy Loveless
Date	26 February 2018

This report is the copyright of Macmillan Cancer Support and has been prepared by ICF Consulting Ltd under contract to Macmillan Cancer Support. The contents of this report may not be reproduced in whole or in part, nor passed to any other organisation or person without the specific prior written permission of Macmillan Cancer Support.

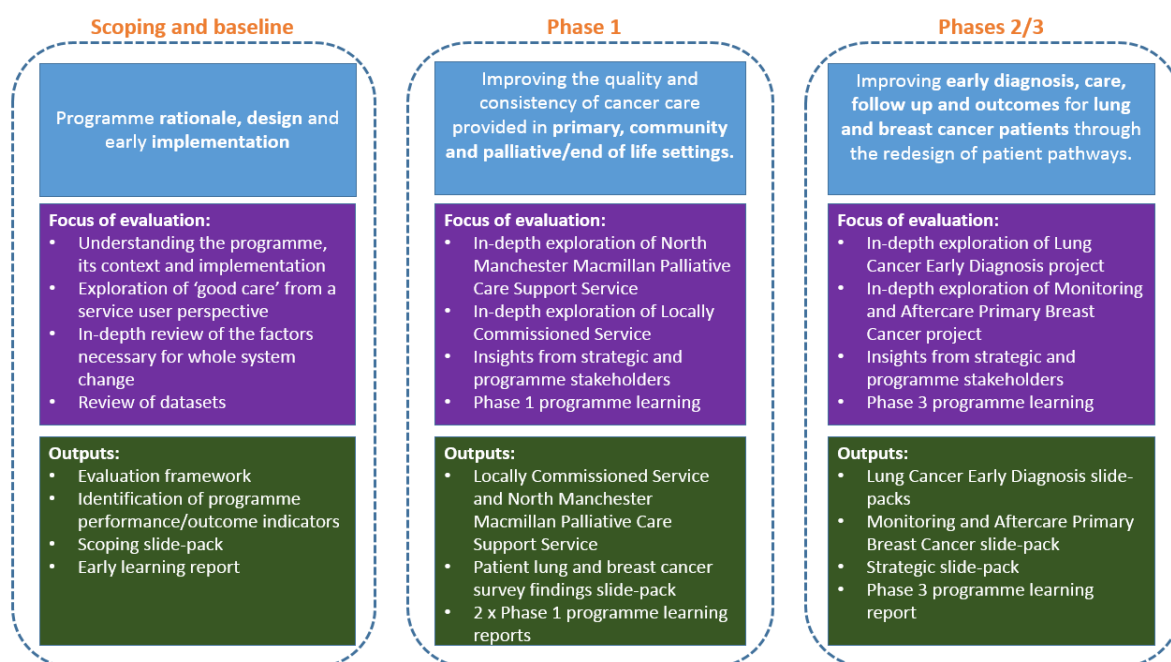
ICF has used reasonable skill and care in checking the accuracy and completeness of information supplied by the client or third parties in the course of this project under which the report was produced. ICF is however unable to warrant either the accuracy or completeness of such information supplied by the client or third parties, nor that it is fit for any purpose. ICF does not accept responsibility for any legal, commercial or other consequences that may arise directly or indirectly as a result of the use by ICF of inaccurate or incomplete information supplied by the client or third parties in the course of this project or its inclusion in this project or its inclusion in this report.

Executive summary

The Macmillan Cancer Improvement Partnership (known henceforth as MCIP) was a partnership between Macmillan Cancer Support, people affected by cancer (PAbC), and nine organisations within the local health economy, which aimed to improve cancer experiences and outcomes in Manchester.

The MCIP Programme was funded by Macmillan and was structured as three interrelated Phases of work: Phase 1 focused on improving the quality and consistency of cancer care provided in primary, community and palliative/end of life settings; and, Phases 2/3, which had a focus on early diagnosis, care, follow up and outcomes for lung and breast cancer patients through the redesign of patient pathways.

ICF was commissioned by Macmillan Cancer Support to undertake an independent evaluation of the programme across all three phases. A summary of the five year evaluation is presented below:



This is the final report from the evaluation of Phase 2/3, providing a synthesis of findings from: a series of semi-structured interviews with key people involved in the leadership and governance of the programme; and two case studies – the Lung Early Diagnosis Pilot and the Primary Breast Cancer Monitoring and Aftercare Pathway - both undertaken in spring - autumn 2017.

The evaluation and scope of this report

The evaluation of the final phase of the MCIP programme was designed to be both formative and summative. It combines a programme-level focus - addressing the design, implementation, impact and sustainability of MCIP as an integrated set of activities alongside a more in-depth exploration of two key areas of work. The report builds on three earlier reports: a scoping report submitted in 2014, an interim report submitted in 2015 focused on programme implementation and early outcomes and a second interim report submitted in 2016 detailing two case studies (on the Locally Commissioned Service and North Manchester Macmillan Palliative Care Support Service) and findings from a series of strategic stakeholder interviews.

This final report presents findings from three strands of evaluation activity:

Interviews with 15 strategic stakeholders: including key people involved in the design, leadership and governance of Phase 2/3. Stakeholders included Macmillan staff at regional and local levels; members of the MCIP management team, workstream and project leads; and PAbC who had participated in the design and delivery of the programme.

Case study one - Lung Cancer Early Diagnosis Pilot: involving 40 in-depth telephone/focus group interviews undertaken with staff involved with the design, early implementation and delivery of the project. The evaluation also explored the experiences and perspectives of people who had attended a lung health check through two rounds of telephone interviews undertaken in 2016 and 2017 (n=22).

Case study two - Monitoring and Aftercare Pathway for primary breast cancer patients: involving qualitative interviews undertaken with 28 stakeholders including Macmillan staff at regional and local levels; members of the MCIP management team, clinical and non-clinical staff and PAbC who were involved in the design of the new pathways. Peer evaluation was an important part of this work, providing a valuable patient perspective. Four PAbC were recruited as 'peer evaluators' through the MCIP User Involvement team and interviewed six patients in total who had experienced follow up care as part of the new breast pathways at UHSM.

For both case studies interview data was supported by evidence from internal evaluation and service monitoring processes.

Case study one - Lung Cancer Early Diagnosis Pilot

There were two components to the Lung Cancer Early Diagnosis service: a Lung Health Check (LHC) which included spirometry, assessment of lung cancer risk and, lung cancer screening with low dose CT scan (LDCT) for those assessed at high risk. Three month follow up scans were offered to those who indicated abnormalities not requiring immediate investigation and a second round of 12 month follow up scans were offered to patients whose risk was assessed as over 1.51%. The service was delivered in community settings from mobile units to make accessibility easier.

Core features of the service included:

- Invitation letters issued to adults in the target demographic. Participating GP surgeries provided details for the patients to the commissioned booking service and the letters were branded and authored on behalf of this GP.
- Interested participants booked appointments through a telephone booking line
- Participants attended a 'Lung Health Check' appointment in a mobile van at one of three identified community venues, involving the completion of a risk assessment and spirometry with a nurse.
- A low-dose CT scan was offered based on risk assessment of lung cancer higher than 1.51% over six years– this was provided in an adjacent mobile van on the same day.
- A second round of 12 month follow up scans were offered to participants whose risk was assessed as over 1.51%.
- Three month follow up scans were offered to those who indicated abnormalities not requiring immediate investigation under an agreed protocol.
- A negative scan result was communicated via letter to patient.
- A positive scan result activated a treatment pathway in secondary care.
- GPs communicated other non-cancerous results to their patients.

Key findings:

The rationale for the Lung Cancer Early Diagnosis pilot was well supported by stakeholders at all levels: Interviewees articulated a range of arguments supporting the need to tackle lung cancer mortality rates in Manchester. These arguments referred to evidence of high cancer incidence as well as poor outcomes – one interviewee reported Greater Manchester has the highest premature mortality rate from lung cancer in England.

The fact that lung cancer can be asymptomatic until it is well advanced, means targeted screening for those at high risk of lung cancer was identified as very important among respiratory clinical and research leads in Manchester. Randomised control trial evidence from the USA also indicated that targeted screening using low dose CT can be very effective in the early detection of lung cancer.

Implementation: The Lung Health Check service was undertaken in highly accessible community venues and successfully reached its target demographic with 75% of attendees residing in areas with the lowest quintile deprivation score. This group are traditionally thought of as hard to engage in screening programmes. Interviewees were clear that the ability of the pilot to reach the target group was due to a number of factors that were built into the design and implementation of the service: extensive public engagement and co-production with PAbC to ensure the messaging and approach

was meaningful and acceptable to the target audience; 'grass-roots' promotion and awareness raising supported by staff in primary care; partnership working between providers and the location of the service in highly accessible community settings. Echoing findings from our other MCIP case studies, the success of the project also rested on a high degree of enthusiasm, expertise and commitment from a range of clinical and non-clinical stakeholders combined with strong senior management, robust project management and strategic oversight and support.

There were a number of challenges reported: At the early development stage, the service faced challenges including locating sites to host the mobile vans, operational difficulties with people being able to get through to book appointments and agreeing the detail of the protocols for reporting scans. As the service developed, other challenges arose including the capacity of radiologists and the demands of reporting timescales, a heavy demand on the service leading to staff working long hours and some difficulties reported by GPs in dealing with the scan reports and knowing how best to support patients with particular results. These challenges have been recognised and many have since been resolved

Achievements and outcomes: The pilot is widely acclaimed as an outstanding success and has achieved national recognition. It has been hugely successful in reaching its target population (including those who are traditionally thought of as 'hard to reach'). A combination of qualitative evidence from the external evaluation and internal NHS data demonstrates the effective achievement of intended project outcomes. 2,541 people attended a Lung Health Check appointment in 2016, with 1,384 undergoing an initial low-dose CT scan following risk assessment. In total 46 lung cancers were detected in 42 people representing a prevalence rate of 3%. The majority of these cancers – 80% - were early-stage and hence more treatable, with potentially curative treatment offered to nine out of ten people with lung cancer. As well as the early diagnosis of lung cancer, the pilot picked up a range of other possible conditions including ischemic heart disease and COPD.

Sustainability: The Lung Cancer Early Diagnosis pilot has received national attention as well as a commitment to fund its replication across north Manchester and inclusion in the Greater Manchester Population Health Plan. At the national level NHS England has recently announced the intention to roll out mobile lung cancer testing centres to other cancer alliance areas, namely in the North East and Cumbria, Yorkshire and Lincolnshire, and London based on this MCIP work. This demonstrates that the project has effected a shift in thinking about lung cancer screening with the potential to create long term change in early lung cancer diagnosis.

Case study two: Monitoring and Aftercare for Primary Breast Cancer Patients

The new monitoring and aftercare pathway was developed for those identified as suitable for self-management¹, in order to better address patient needs and reduce the requirements for consultant-led outpatient appointments at PAHT and UHSM.

The new pathway separates annual mammographic surveillance from the annual clinic appointment and patients receive a longer, 45 minute, "Moving On" appointment from a Clinical Nurse Specialist (CNS). The longer appointment focusses on providing holistic, person-centred support, coupled with referral into a comprehensive "Macmillan Recovery Package" which may include all or some of the following (on a needs-led basis):

- Production of a written treatment summary;
- A Holistic Needs Assessment (HNA);
- A written care plan; and
- Referral to Health and Wellbeing (HWB) events.

A further key component of the new pathway is the CNS-led telephone triage service. This is a formalised triage service that allows patients to call in and receive advice from a CNS whenever they

¹ Clinical teams, commissioners and PAbC worked together to agree a clear risk stratification approach to identify who would be suitable for self-management-based follow up. Inclusion criteria includes: patients with Stage 1 or 2 Breast Cancer, those receiving curative treatment with no current effects and patients with good general fitness, understanding of their care pathway and willingness to self-manage.

need. If a CNS is unable to speak to a patient immediately, the patient will receive a follow-up call within 24 hours.

Key findings:

The rationale for the new monitoring and aftercare pathway was well understood and supported: In light of improving treatment outcomes and longer life expectancy, the new pathway was established with the aim of enhancing the follow-on support provided to patients with primary breast cancer. The previous model of aftercare (with an annual mammogram and an annual clinic review with a breast clinician or CNS) was not felt to be sufficient to properly address the spectrum of patient needs and increasing pressure on consultants meant that patients often had long waiting times to see them. The new pathway was designed to provide more holistic and nurse-led support to patients that better equips them to self-manage.

Factors supporting implementation: Interviewees articulated a number of factors that underpinned the success of the project: a clear and shared rationale for change; strong engagement and buy-in from PABc, nurses and senior clinicians, particularly during the design phase; excellent team working, the role of the Aftercare Coordinators in facilitating patient access; and the passion and skills of particular individuals, including the project lead.

Challenges: The project faced some challenges, including a delay in development of an IT solution to support patient appointments, an increase in workload of CNSs and limited engagement with the new pathways by a minority of consultants. These challenges were identified and dealt with at an early stage and on-going challenges around CNS capacity are being overcome through cascade training.

Achievements and outcomes: Findings from the internal MCIP evaluation and peer research interviews reflect that the service has been well received by patients, the majority of whom report feeling well supported and satisfied with the care they receive. The internal MCIP evaluation shows that 94% of patients (124/132²) were satisfied or very satisfied with their breast cancer treatment. Patients report being able to discuss wider concerns (such as relationship worries) and feeling empowered to self-manage. There is also emerging evidence that patients using the telephone service are “asking the right questions” demonstrating knowledge of how to self-manage effectively. Qualitative feedback indicates that the implementation of the new pathway has improved team working and increased job satisfaction for nurses who report feeling ‘empowered’ through their involvement in the delivery of change. Breast Cancer Nurse Specialist teams at UHSM and PAHT have also recently won a Macmillan National Service Improvement Excellence award for their work in redesigning breast cancer pathways to transform aftercare for women with breast cancer across Manchester. Anecdotal evidence suggests that the new pathway is freeing up consultant time to see more complex patients and has delivered “*increased value for the same cost envelope*”. More widely, the new model of aftercare has supported a more standardised approach to follow up care and monitoring bone health.

Sustainability: Both strategic and delivery staff were confident that change would be sustained at the end of the funding period as the new model of care becomes embedded as ‘business as usual’. This has been boosted by continued funding for Aftercare Co-ordinators with a view to making these, and a number of other posts at UHSM and PAHT, permanent. Elements of good practice from this work has provided the foundation for establishing a sustainable pathway that is now providing a blueprint for replication across Greater Manchester.

Reflections on MCIP: factors contributing to the programme’s success

Findings set out in our previous Phase 1 report, together with those presented here, provide strong evidence of the success of the MCIP programme as a whole. In many respects, the programme has

² All patients at PAHT with a breast cancer diagnosis and all patients at UHSM who had been assessed as suitable for self-management were asked to complete a satisfaction questionnaire. A total of 132 questionnaires were received; 33 questionnaires were returned by PAHT and 99 by UHSM.

exceeded expectations; interviewees described MCIP as a complex and ambitious programme that has reaped a number of outstanding successes.

“The achievements that have come out of it despite those challenges, complexities and the changing picture of the cancer landscape is significant. I don’t think that achievement can be underestimated.”

Key achievements

There have been achievements across the whole cancer pathway from awareness raising (through the Macmillan Information Points), to earlier diagnosis (with the Lung Health Check pilot), to living with and beyond cancer and palliative and end of life care. Interviewees were clear that the programme as a whole has achieved its original objective of delivering an integrated set of activities, with the Phase 1 foundational work done in primary (and to a lesser extent community) care perceived to have “*paved the way for the breast and lung work*” in Phases 2/3. There have been a number of major successes from the programme; in addition to the two case studies detailed in this report, two other key areas of work are summarised below. While these are by no means the only achievements made by the programme, they represent key areas of work that have fallen within scope of the evaluation.

The reconfiguration of community palliative care services in North Manchester through the North Manchester Macmillan Palliative Care Support Service (NMMPCSS). The service has served as a model to roll out to the rest of Manchester, recognised nationally, and has moved from pilot to fully commissioned service. There is robust evidence of concrete outcomes being delivered through the service including increased numbers of patients identified on palliative care registers and higher percentages of patients achieving their preferred place of care.

The Locally Commissioned Service (LCS), which was key in developing the capacity of primary and community care providers to deliver cancer care. This paved the way for the implementation of Phase 2/3, through upskilling and training practice staff to act as clinical and non-clinical cancer champions, improving systems and processes such as the use of cancer review templates, cancer care registers and embedding more regular MDT meetings. The LCS secured a sign up rate of over 90% of GP practices, with the non-clinical cancer champions a particularly successful feature of the service.

Critical factors underpinning success

There was a high degree of consensus among interviewees of the key factors underpinning MCIP’s success:

- **A shared vision and strong rationale for change:** A consistent theme across all phases of the MCIP evaluation has been the extent to which stakeholders have articulated a shared rationale for, and commitment to making change happen. The volume and complexity of the work presented a huge challenge but the programme has succeeded in establishing a coherent and shared vision for transforming cancer services in Manchester.
- **A willingness to take risks and embrace innovation:** Some of what has been achieved has been through enhancing existing practice, improving communication and collaboration between primary and secondary care and embedding more effective systems and processes. Other elements are recognised as highly innovative, having involved a degree of risk taking, albeit evidence based, to move into new areas of pioneering practice. The ability of the programme to work in this way rests in part upon the strength of relationships and trust between stakeholders who have worked hard to build this over the lifetime of MCIP.
- **Strong engagement and ownership at all levels enabling change to be co-designed:** A key strength of the MCIP programme has been the inclusive approach taken to engagement, with the emphasis on collaborative working with a range of stakeholders including PAbC, service providers, commissioners and clinicians. The programme has invested time and resource in building strong partnerships and relationships, which “*has paid off hugely*”. Interviewees considered this key to enabling a co-designed model of change owned at both strategic and operational levels. Relationship building and securing trust has been key to achieving change that has been owned at the local level.
- **Engagement of PAbC facilitated by dedicated resources:** Co-production with PAbC sits at the heart of Macmillan’s ‘Redesigning the System’ programme. Interviewees gave credit to both Macmillan and the programme team for ensuring that this has also been integral to MCIP, with all

work streams guided by the aim of improving the experiences of, and outcomes for, PAbC. The meaningful involvement of PAbC requires time and resourcing and Macmillan was commended by interviewees for having made sure that the active participation of PAbC in the MCIP programme has been well-resourced throughout. This has been in the form of provision for a dedicated User Involvement Facilitator (UIF) post as well as through enabling access to Macmillan's national resources, including training opportunities. This helped build a team of 25-30 PAbC who were involved in the programme and supported on a 1:1 basis. The feedback from PAbC who were directly involved was also generally positive and the support that they had received was highly praised.

- **The central role played by Macmillan:** Over five years, Macmillan invested £5.65 million in MCIP, an investment which all interviewees described as an essential factor in the programme's development, implementation and legacy. Alongside the substantial level of funding, interviewees praised the Macmillan brand, which has provided a strong identity for the programme as well as the portfolio of central resources that Macmillan has been able to offer to MCIP. Crucially, the Macmillan name has also promoted the involvement of PAbC with Macmillan driving and maintaining the focus on involving PAbC as well as encouraging PAbC to get involved. Macmillan was also felt to have shifted ground, moving from a more 'top-down' 'transactional' position to arrive at a flexible, facilitative and less prescriptive approach to supporting system change:
- **Strong leadership achieving a balance of designated and distributed leadership:** A strong theme emerging from our final round of stakeholder interviewees was that MCIP has benefited from a combination of strong leadership at the strategic, programme and project levels combined with dedicated buy-in from clinical, managerial and other front-line staff. The keen attention paid to engagement and facilitating a shared vision for change has enabled the development of a collaborative and dispersed leadership style whereby 'everyday leaders' as well strategic 'change agents' have played an important role in implementing change.
- **Dedicated programme management supported by robust governance arrangements:** Distributed leadership has been supported and enabled by rigorous programme management underpinned by robust governance arrangements. The programme team was credited with having built the infrastructure to support collaboration and engagement, providing coordination and integration, contributing capacity where necessary and keeping the work on track to ensure project milestones were met.
- **Having the right people on the ground to make change happen:** MCIP was also recognised as having had the 'right' people at the programme, project and operational levels. These individuals were praised for their hard work, passion and commitment and recognised for their ability to build networks, inspire their colleagues and 'get things done'. MCIP has created, developed and drawn on a number of posts/roles throughout the lifetime of the programme that interviewees commonly highlighted as critical, including the Cancer and Palliative Care Facilitators and Macmillan GPs. As well as dedicated post-holders, the hard work and commitment of both clinical and non-clinical staff tasked with supporting and implementing new initiatives and pathways was praised.

Sustaining achievements

A number of factors were reported as underpinning the ability of the programme to deliver sustainable change:

Plans for sustainability were built in to the programme's workstreams from the outset and internal and external evaluation work delivered timely evidence to support the case for continued funding or recommissioning of specific elements of work. This has helped major areas of work such as the NMMPCSS and the new breast cancer pathways become established as 'business as usual' models of care.

The programme was embedded in a commissioning organisation which has enabled the programme team to work 'within the system' and support sustainability through securing both clinical support and commissioning commitments. A key success has been the commissioning of the NMMPCSS as a mainstream reconfigured service for the north of the city with roll out to the rest of Manchester to follow in the near future.

MCIP and the local health economy continued funding for key posts across the programme which have been critical for embedding change, including the role of the breast Aftercare Coordinators. At the end of Phase 1, both MCIP and the local health economy also invested resources

to enable a Cancer and Palliative Care Facilitator to remain in post to support longer term delivery of the changes made in primary care as part of the LCS.

MCIP has set standards for care that promote replication providing blueprints for system change in other parts of the city, which promotes equity of access and consistency of care. The Lung Cancer Early Diagnosis Pilot, the new monitoring and aftercare pathway for breast cancer patients and NMMPCSS are all examples of projects, which have provided templates for change across the area.

Elements of the programme were well-aligned with wider strategic priorities and the national and local direction of travel. On-going momentum and support is contingent upon the degree of strategic fit between the programme, national policy developments and Manchester's broader aspirations for the local health system. This is particularly in relation to earlier diagnosis and the living with and beyond cancer agendas as set out in the Five Year Forward View. MCIP was also described as shaping the Greater Manchester Cancer agenda.

Showcasing and communicating MCIP's achievements has ensured that experiences and outcomes are shared with a wide range of stakeholders. Key projects have provided best practice models for replication both in Manchester and elsewhere, for example national recognition of the Lung Cancer Early Diagnosis pilot is demonstrated by the adoption of a similar approach in Leeds and the recent NHS announcement that it will be funding the development of schemes similar to the Lung Health Check in other parts of the country.

While there is strong evidence of sustainability of key components of the MCIP programme interviewees expressed some areas of concern. These included: limits to the ability of commissioners to secure change through the contracting process and potential loss of both the "goodwill of clinicians", and the active and meaningful engagement of PAbC in the on-going development of cancer services in Manchester when MCIP concludes. Most commonly, concerns centred on the sustainability of achievements of the LCS as continued implementation would be dependent on the buy-in and ability of staff in primary care.

Conclusion

The MCIP programme has been a complex, highly ambitious programme that has reaped some outstanding successes. It is credited with having achieved "transformational change" making "*big differences across boundaries and care settings*". A combination of evidence from this external evaluation and internal data collection provide robust evidence of the overall success of the MCIP programme.

There is good evidence emerging that MCIP has supported system change beyond the boundaries of its original programme of activity. The programme is credited with having provided blue-prints for pathway redesign across the city and for other cancer types thus supporting a move towards better quality and consistency of care. MCIP has also yielded important learning for others for effecting large scale system change. Interviewees were confident that key components of the programme would be sustained beyond completion indicating that MCIP will have a significant and long-term impact on the local system of cancer care.