RM Partners

West London Cancer Alliance

Hosted by The Royal Marsden NHS Foundation Trust

Transformation Programme Evaluation

Final Report

June 2020

Working in partnership, ***we will achieve world class cancer outcomes*** *for the population we serve*

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Executive summary

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Executive summary

Evaluation overview	• RM Partners (RMP) is the West London Cancer Alliance. Along with its partners across the Alliance, its central team is leading the local implementation of the NHS Long Term Plan in North West and South West London, and is responsible for **over £10 million in annual funding for transformation of cancer services**. • RMP commissioned **Frontier and NatCen to independently evaluate** a subset of these activities, focusing on the colorectal and lung cancer pathways, as well as the role of RM Partners as a system leader, locally and nationally. • Evidence was gathered primarily over the period January to March 2020. Participant views gathered may not in all cases be representative of wider perceptions.

Role of RM Partners as a system leader: summary findings

- RM Partners is widely considered a **valued system leader** in West London, bringing together organisations to improve cancer services. It performs a valuable function in managing transformation projects, facilitating the trial and spread of innovation across partners, generating evidence of intervention effectiveness, addressing poor performing pathways and providing transparent data and analysis.
- RM Partners has been **effective in securing and distributing national funding**, based upon its understanding of local need, seeking to maximise the impact for its local population and ensuring wide participation in innovation/research among its members.
- RM Partners has developed **strong networks** at senior and frontline level, supported by RMP governance structures.

We recommend that RMP continues to build on the above strengths and further enhances its existing capability in the following ways:

- **Expand RMP reach further into primary care:** further develop effective working with **primary care and** PCNs, recognising that PCNs are relatively new organisations with many priorities and therefore to date have been limited in their ability to engage with RMP.
- **Continue to focus on long-term sustainability of new services:** planning the sustainability of innovations beyond the period of trial funding, enhancing ongoing monitoring and ensuring targeted and value-added data collection.
- **Continue to adapt to local needs over-and-above national priorities:** building on its strong collaborative approach to ensure local prioritisation reflects, and is adapted to, local needs, including addressing health inequalities.

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Lung pathway projects: summary findings

Targeted Lung Health Check (TLHC): Former or current smokers, aged 55-74*, were invited for an initial symptom check and (for those with specific risks factors) a low-dose CT scan. TLHC aims to identify lung cancers earlier. Over January – March 2020:

- Checks were seen by patients as **efficient and effective**
- Attendees of Phase 2 (Jan-Mar 2020) tended to be **'regular attenders'** of screening or health checks.
- Compared with Phase 1, Phase 2 **achieved a higher uptake,** among a **somewhat different patient cohort**.
- **We recommend** RMP considers refining pre-check patient information, and tests new ways of encouraging 'harder-to-reach' individuals to attend.

Best Practice Straight to Test Pathway (STT): This package of interventions keeps patients with suspected lung cancer within secondary care post-referral, speeding up their times between tests and progress along the pathway. Services have been reorganised to accommodate STT progression and dedicated staff are accessible to patients needing support along the pathway.

- **RMP has added value** to the project through its project management, sharing information and data analysis.
- **We recommend** 'making the case' for dedicated patient-facing roles and provision of more non-English-language information.

Colorectal pathway projects: summary findings

Faecal Immunochemical Test (FIT): FIT is a diagnostic tool for patients showing certain symptoms indicative of bowel cancer, which can be completed by patients at home. A core aim is to allow for effective triage of colonoscopies and prevent patients undergoing this procedure unnecessarily. Over January - March 2020:

- FIT kits have been completed by **at least one patient from each GP practice** in the Croydon pilot area. However there is variation and significantly higher uptake could be possible.
- It is possible that the introduction of FIT kits has changed GP referral patterns but this has not yet been tested.
- **Some GPs raised concerns** about the rollout of FIT potentially delaying access to secondary care, although this was considered low risk by clinicians who designed the intervention.
- Early tentative data from secondary care suggests that the completion of a **FIT kit is not influencing the diagnostics undertaken at hospital,** including colonoscopies.
- **We recommend** greater primary care engagement, further analysis of secondary care referrals and activity, close monitoring of uptake and variation, and continued measurement of the impact upon colonoscopy activity and costs.

** Individuals aged up to 74 years and 364 days*

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Key points for RM Partners

Based upon all the evidence we have gathered, the Evaluation Team invites RM Partners to consider the following key points:

Areas of strong performance

- RM Partners has developed a **strong network of organisations**, supported by good relationships at multiple levels within those organisations; collaborative ways of working; and inclusive governance structures.
- This has been reinforced by valuable activities such as **joint decision-making for agreeing local priorities.**
- Its effectiveness has also been underpinned by ensuring the **voice of smaller/less specialist trusts is heard**, a **collaborative 'risk-sharing' approach** to performance, and **perceptions of 'fairness'** within the Alliance.
- This has enabled other successes, such as identifying and spreading best practice; upskilling trusts; addressing local performance issues; promoting innovation; securing funding; and ultimately the **improvement of cancer services**.
- The future success of RM Partners is likely to depend upon its ability to **build on these strengths** while also being flexible, adapting as the wider system evolves, and focused on local needs and priorities.

Areas of potential focus

- Recognising the importance of **primary care** in the cancer care pathway, it will be important for RM Partners to build on its progress in engaging primary care representatives **and** to further deepen its relationships with Primary Care Networks.
- The opportunities and challenges arising from **Integrated Care Systems** are likely to require RM Partners to be sufficiently flexible and adaptable to ensure it is able to effectively support and influence ICS decision-makers.
- **Continue to focus on long-term sustainability of new services:** planning the sustainability of innovations beyond the period of trial funding, enhancing ongoing monitoring and ensuring targeted and value-added data collection.
- **Continue to adapt to local needs as well as national priorities:** building on the strong collaborative approach of RM Partners to ensure local prioritisation reflects, and is adapted to, local needs, including addressing health inequalities.
- Capitation funding for cancer alliances has diminished RM Partners' **historical ability to 'overachieve' in securing national funding**. RMP could consider focusing more on demonstrating the other elements of the alliance's value-added.

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Introduction

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Evaluation overview

- RM Partners is the West London Cancer Alliance. It brings together 10 trusts across 14 CCGs in 2 STP areas.
- RM Partners is leading the **implementation of the Long Term Plan in West London**.
- The Alliance is responsible for **over £10 million in funding for transformation of cancer services**. In 2019-20 this was allocated to around 20 broad service improvement projects, covering different cancer specialisms, geographical areas, and improvement priorities.

West London Cancer Alliance

- The **overall objectives of RM Partners** include achieving earlier and faster cancer diagnosis; increasing population access to best practice care; and providing national leadership through the introduction and spread of innovative, world-leading cancer care.
- In order to understand the impacts and effectiveness of this transformation funding, RM Partners commissioned **Frontier Economics and NatCen Social Research**. We were asked to independently evaluate a subset of these activities, focusing on the colorectal and lung cancer pathways, as well as the role of RM Partners as a system leader across all of its activities.
- The evaluation is both summative (assessing performance to-date) and formative (identifying potential improvements) in nature. We also considered both process and impact. We used a **mixed methods approach** including: documentary review; quantitative analysis of costs and activity; semi-structured, in-depth interviews; and a patient survey. Our evaluation approach is in line with Government Social Research standards, HM Treasury's Green and Magenta Books and **NHS England evaluation best practice**.
- Work was undertaken between **August 2019 and May 2020**. Due to the Covid-19 pandemic arising in March 2020 **the evaluation period was curtailed** and some of the intended fieldwork during the latter stages this project was not feasible.

Evaluation framework

- Our work was guided by the following overarching framework and stages of work

Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Define pathways and interventions of interest	Prepare logic models	Determine evaluation questions	Scope available data and stakeholders	Select appropriate evaluation method	Carry out analysis, interpret and report
• Specify and describe the interventions to be evaluated • Define the goals and objectives of the interventions • Define the goals and objectives of the evaluation (formative and summative)	• Define the inputs, outputs and outcomes required for strategic objectives to be achieved • Develop logic chains to demonstrate the channels through which impacts will be realised	• Specify key questions on which the evaluation should focus • Determine the appropriate timing of evaluation • Decide which spatial areas and populations on which to focus	• Assess evidence and data availability against evaluation questions • Identify stakeholders and areas in which they can provide insights and evidence • Identify whether quant or qual are most appropriate • Compile quant indicators and qual topic guides	• Consider the options for evaluation • Consider proportionality and level of rigour to be achieved • Set out hypotheses to test through the evidence (what we expect to see)	• Present descriptive statistics to describe the context, recent trends and baselines • Undertake evaluation analysis • Describe findings, drivers of results, contextual factors and limitations

Evaluation scope

- We agreed with RM Partners to focus our evaluation on the following areas.
- We undertook **formative** evaluation across all activities considered. For some projects considered it was also possible to undertake **summative** evaluation, however due to the timing of implementation this was not possible for all projects.

Role of RM Partners as a **system leader**	• Exploring the **system-wide effectiveness of RM Partners** – formative and summative

Role of RM Partners in improving the **lung cancer pathway**	• Focus on two RMP-funded projects:
	  • **Best Practice Straight to Test Pathway (STT)** – formative evaluation
	  • **Targeted Lung Health Check (TLHC)** – formative and summative evaluation

Role of RM Partners in improving the **colorectal cancer pathway**	• Focus on three projects:
	  • **Faecal Immunochemical Testing (FIT)** – formative and summative evaluation
	  • **Personalised Stratified Follow-up** – formative evaluation
	  • **Bowel Screening (Community Links patient engagement)** – formative evaluation

Evaluation questions

- Our work was guided by the overarching evaluation questions. These were used, for example, to develop detailed 'topic guides' which were used to guide the semi-structured interviews.
- The evaluation questions varied across areas of RMP activity. A high-level summary is shown below.

	High-level evaluation questions
System leader	• What do interviewees understand to be the main aims and activities of the RMP? • What outcomes has RMP facilitated that would otherwise not have occurred? • How effectively has the RMP worked with the partners in the Alliance? • What are the key ingredients to the success of the RMP Alliance? • What challenges does RMP face now and going forward?
Lung pathway Colorectal pathway	• What are the key ingredients for successful implementation? What are the barriers? • Are interventions cost-effective and how does this compare with existing / alternative options? • Do interventions achieve clinical objectives and good patient experience, and how does this compare with existing / alternative options? • What are the wider system impacts from interventions? • How can we best monitor performance for future project implementation?

Evaluation activities

- We used a **mixed methods approach**. Quantitative data – where available – is able to indicate the scale of impact or effectiveness. Complementing this, qualitative evidence provides a richer understanding about: the context to the interventions; the conditions under which different outcomes arise; and interpretations of the data. More widely, qualitative fieldwork formed the primary evidence for the formative evaluation to understand the implementation.

		Document analysis	Stakeholder interviews	Patient interviews	Survey	Quantitative analysis	Evaluation framework
System leader		✓	✓				
Lung pathway	Best Practice Straight to Test Pathway	✓	✓				✓
	Targeted Lung Health Check	✓	✓	✓	✓	✓	✓
Colorectal pathway	FIT	✓	✓			✓	✓
	Personalised Stratified Follow-up	✓					✓
	Bowel Screening	✓					✓
			23 participants	21 participants	193 respondents		

Note: due to delays in project implementation, quantitative analysis of impact was limited. In addition, due to these delays and also the Covid-19 pandemic, around 30 planned interviews (patient and stakeholder) were not undertaken at request of RMP.

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Role of RMP as a system leader

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Role of RMP as a system leader

Overview

Overview of evaluation approach

- Our research approach was led by a series of semi-structured interviews with RMP stakeholders.
- We interviewed 13 participants from a diverse mix of organisations e.g. NHS England, STPs, CCGs, Trusts, as well as RMP Senior Management Team.
- Diverse mix of high-level job roles e.g. Chief Executives/Managing Directors, Medical Directors, and Strategic Leads.

RMP system leader role

Aims

- **Improving cancer services**, consistent with national cancer strategy.
- **Lead innovation and spread**, evidence generation, and shared learning.

Activities

- **Project management and delivery** to implement a range of programmes, jointly with local trusts and stakeholders.
- **Business case support** for national transformation funding, including development of local business cases to support sustainable implementation of sponsored innovations.
- **Data analytics** on performance metrics, activities and patients.
- **Operational support** for improving poor performing pathways.
- Distribution of transformation **funding** across partners.
- Facilitating **partnerships to trial innovations** and support roll-out.
- Actively **galvanise the Alliance partners** across West London.

Successes and challenges

Successes

- RMP is perceived by stakeholders to be a system leader that brings together and supports partner organisations to **improve cancer care** across West London.
- Positive influence on evidence-based **innovation** in cancer care and roll-out across the Alliance e.g. C the Signs tool.
- Successfully leading new **evidence generation** and exerting **national influence** e.g. the RAPID prostate cancer pathway, FIT roll-out.
- Leadership skills in **bringing the right people together** at multiple levels across partner organisations e.g. Executive Board and Clinical Oversight group.
- **Prioritise and secure funding** for innovation, and spread innovation across West London.
- **Project management** support for a range of transformation projects to drive improvement in cancer services.
- Hands-on support for **poorer-performing pathways** and collaborative working with other trusts.
- **Supporting smaller trusts** who might otherwise have a 'smaller voice', helping them with research and innovation, and to secure access to funding.

Challenges

- Managing the delivery of **national priorities within a local system** which itself has different priorities, context and needs.
- Inevitable need to prioritise funding on some aspects of performance means **other aspects less in focus** e.g. driving up average performance vs minimising variation.
- **Primary care** (including screening programmes) is an essential element of earlier diagnosis yet very hard to engage due to fragmented structure of the primary care system.

Barriers and enablers

Barriers

- Ability of RMP to 'do more' often depends on **securing additional funding**, which may be increasingly hard to secure given the move to population-based funding allocations.
- **Achieving early diagnosis** is an aim but this is inherently very difficult as it means **identifying patients who are asymptomatic** – presentation in primary care or secondary care is already relatively late.

Enablers

- **Clear aims** to improve cancer services. Supported by commitment to improvement across the Alliance and **'risk pool' approach** where poorer-performers are supported to improve by stronger-performers.
- Skills of the leadership team in RMP in terms of **bringing partners together and nurturing relationships**. Active commitment and effort to galvanise **partnership working at all levels**, creating a 'web of relationships' that enhances effective change management. Building on the solid foundation of existing London Cancer Alliance relationships.
- **Flexible and responsive** to the needs of the Alliance partners.
- **RMP provides a 'neutral space'**, facilitating cross-organisational collaboration and mediating conflicting interests.
- Focus on **data and evidence** and sharing this widely and transparently across the Alliance.
- **Sustained, multi-year funding** enabled more challenging work on diagnostic pathways to be undertaken, evidenced, and published.
- **Business case support**, upskilling trusts and securing access to funding. RMP have 'punched above their weight' in securing funding.

Potential opportunity

- The system-wide **introduction of Integrated Care Networks** could change the way RM Partners works in the future. This could become a barrier or an enabler.
- Ideally **RM Partners can use this to their advantage** e.g. by building new relationships (and potentially governance arrangements) which reflect and reinforce these new ways of working.

Practical recommendations

RM Partners is invited to consider…

RMP system leader role

Continue to focus on long-term sustainability of new services	• Adapt to new capitation funding for alliances, if necessary modifying existing approaches to **prioritise and distribute available funding effectively**. • Continue to take the lead in building a **systematic process for learning from projects**, embedding interventions, planning and resourcing roll-out. Engage with Trusts to minimise the extent to which they are doing this in silos, and communicate widely within Trusts to ensure awareness and support.
Foster integrated, multidisciplinary approaches	• Continue bringing people together, **breaking down clinical/practice silos,** including through personalised care activities. Continue moving organisations toward integrated care and multidisciplinary teams. Maintain an **organic and evolutionary approach**. • Draw upon existing range of **vertical and horizontal collaboration activities** rather than taking a top down approach, supported by planned changes to RMP ways of working which involve even greater primary and secondary care involvement.
Expand RMP reach further into primary care	• Primary care engagement is vital but has been identified as an **area of challenge** due to the relatively fragmented nature of the sector and the competing demands it faces. • Learning how to **work effectively with Primary Care Networks** may provide a good opportunity. RMP governance structures could be modified to enable this.
Continue to adapt to local needs over-and-above national priorities	• Building upon the strong collaborative approach of RMP to ensure **local prioritisation reflects, and is adapted to, local needs**, including addressing health inequalities. Capitation funding to deliver national priorities may allow an even stronger local focus on going 'over-and-above'. • Ensure that efforts targeted at **local health inequalities** are given prominence among local stakeholders to build awareness and support, and that the reduction of such inequalities is included in the prioritisation process.

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Lung pathway – project-specific findings

Overview

Overview of evaluation approach

- Our research into the Targeted Lung Health Check included
  - A survey of TLHC attendees (193 respondents)
  - Semi-structured interviews with 21 TLHC attendees
  - A workshop of 4 staff involved in the delivery of TLHC
- Our research into the Best Practice Straight to Test Pathway project was based upon semi-structured interviews with 3 stakeholders.

Targeted Lung Health Checks

- Targeted Lung Health Checks (TLHC) are offered to individuals aged 55-74* who are former or current smokers at risk of lung cancer.
- This project is designed to increase the uptake of TLHC at the Royal Brompton Hospital. Phase 1 was implemented across Hammersmith & Fulham and Hillingdon CCGs. Phase 2 – the focus of this project – takes the learning from Phase 1 and refines the approach to inviting individuals e.g. the format and wording of the letter they receive.

Best Practice Straight to Test Pathway

- This project focuses on helping trusts to achieve the 28-day Faster Diagnosis Standard, and improving patient experience for those suspected of lung cancer.
- The project involves refining processes in secondary care, speeding up the times between tests and progress along the pathway. Innovations include accommodating 'Straight to Test' (STT) from GP referral, and dedicated staff who are accessible to patients needing support along the pathway.

** Individuals aged up to 74 years and 364 days*

TLHC attendee uptake

- Both Phase 1 and Phase 2 were implemented in 17 GP Practices across Hillingdon and Hammersmith and Fulham CCGs. Phase 2 of TLHC operated between January and March 2020.
- Phase 1 invited 60-74 year old smokers or ex-smokers; Phase 2 invited 55-60 year old smokers or ex-smokers, those who did not respond in Phase 1, and new GP registrants who were eligible.
- A primary aim of the Phase 2 trial was to increase patient uptake. In Phase 1, some 21% of patients invited chose to attend a check.
- We analysed early data from the Phase 2 TLHC trial. This was somewhat limited data due to a delay in starting Phase 2 (January 2020) and early winding-down of the service due to Covid-19. As a consequence, results may not be reflective of long-term settled performance.
- Amongst the newly invited patients, there is **some evidence of increased patient uptake, to 28%**. Although we note that because of the change in age band, these patients are not directly comparable to the Phase 1-invited patients.
- Amongst the re-invited patients who did not originally attend TLHC, 17% chose to attend a check. This suggests that re-inviting patients may be an effective strategy.

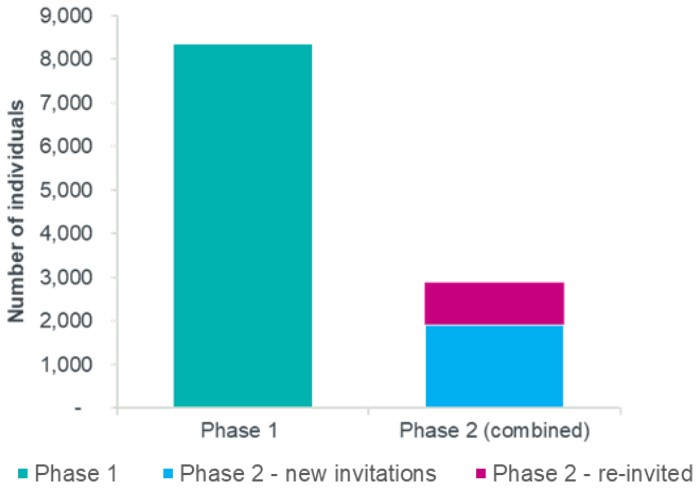
21%

Uptake of lung health checks in Phase 1 trial amongst newly-invited eligible patients

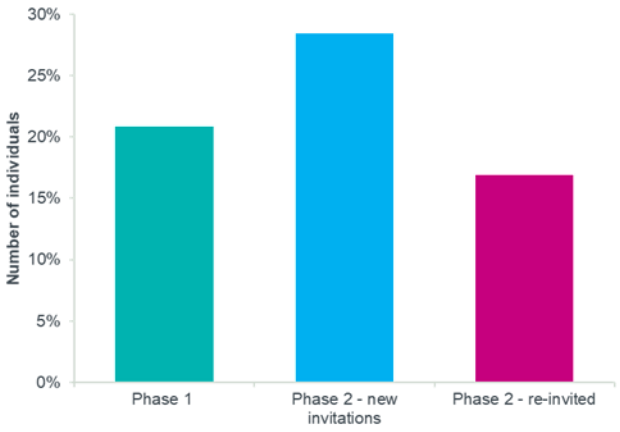
28%

Uptake of lung health checks in Phase 2 trial amongst newly-invited eligible patients

Invitations



Attendances



Source: Frontier based on RM Partners TLHC data

TLHC attendee variation

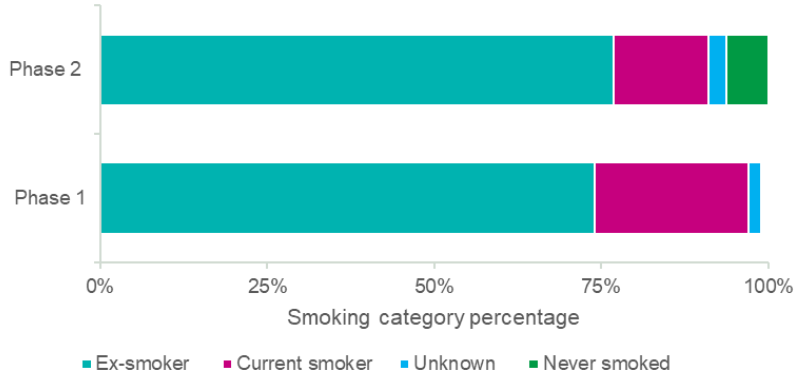
- We observed some differences in the characteristics of people attending.
- In particular, amongst Phase 1 attendees around **23%** were current smokers and the remaining **74%** were ex-smokers. **2%** of those attending were non-smokers.
- In Phase 2, a slightly higher proportion of ex-smokers attended (**77%**), fewer current smokers (**14%**), and also 9**%** were non-smokers or had unknown smoking status.
- It is unclear whether these differences were due to inviting a different group of people, or whether the approach in Phase 2 attracted different individuals to attend.
- The baseline scan figures are not included as there are patients who opted in, but had their baseline scan postponed due to Covid-19.
- However, it is expected that the number of patients who have a CT scan will be lower than phase 2 due to:

  1.The age of those invited in phase 2 including a **younger cohort** of patients who are lower risk; and

  2.The **risk score** required in order to be referred to a baseline increasing.

- The overall number of patients invited and respondent numbers for each patient group invited are shown.
- Note the analysis is **descriptive** due to the sample size and data available. It is not possible to confidently draw conclusions but it presents the raw data which is able to offers some indicative conclusions

Smoking status of attendees



Overall results

	Phase 1	Phase 2		
	All individuals	All individuals	New registrants	Re-invited
Total number invited	9,245	3,172	2,127	1,045
Total not eligible	879	304	221	83
Total number invited and eligible	8,366	2,868	1,906	962
Respondents	2,628	1,010	764	246
Eligible respondents	1,749	706	543	163
Baseline scans	1,145	*Omitted due to Covid-19*		
Respondent rate (eligible)	21%	25%	28%	17%
Respondent rate (all)	28%	32%	36%	24%
Conversion rate	65%	*Omitted due to Covid-19*		

Source: Frontier based on RM Partners TLHC data

TLHC survey – attendee motivations

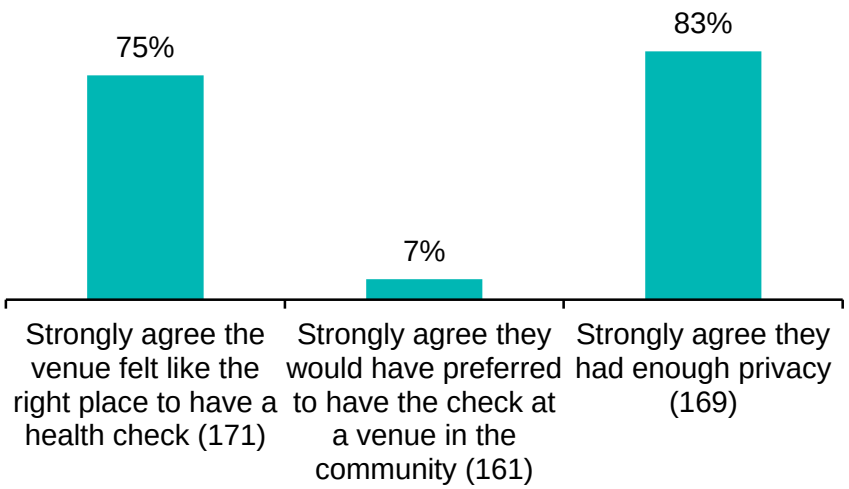
- We delivered a **structured survey** to support this evaluation. All patients who attended a check between January and early March 2020 were invited to complete this. A total of **193 patients** had completed the survey.
- We note that **survey respondents had all attended a TLHC**. Their views may be different to those who decided not to respond to the invitation e.g. those who found the information poor or the venue inconvenient may have been more likely to not attend.
- Our survey suggests that most **people attending a TLHC are 'usual attenders'** – over 90% said that when invited to other health checks they usually or always attend. This suggests **TLHCs may not be attended by 'harder-to-reach' groups**.
- **Most attendees received information about the TLHC by letter**, and some by phone. Very few received information from other sources e.g. seeing a poster (1 respondent), text messages (3) and emails (2).
- The **clear majority found the TLHC information helpful**: 73% reported they were 'very helpful' and a further 17% that they were 'fairly helpful'.
- The **most common motivation for attending was simply that they had been invited to do so** (88% of respondents). This suggests that **most people's reasons for attendance were reactive**.

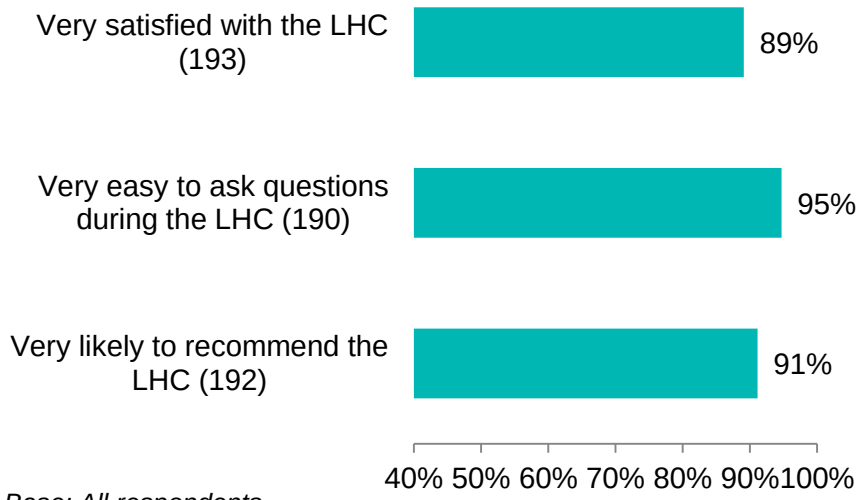
Source of invitation	**N=187**
Letter	176 (94%)
Phone	16 (9%)
Poster in GP surgery	1 (1%)
Other	6 (3%)

How often people attend other health checks they are invited to…	**N=192**
Always attend them	140 (73%)
Usually attend them	35 (18%)
Occasionally attend them	5 (3%)
Don't know	2 (1%)
Never been invited to one before	10 (5%)

TLHC survey – attendee experience

- For the vast majority of survey respondents, **attending a TLHC was a convenient process**.
- All respondents to the survey said they were able to **book an appointment for a convenient time**.
- People took on average 36 minutes to get to the TLHC, and very few (5%) had a journey time longer than one hour.
- Nearly four fifths (79%) of attendees strongly agreed **the venue was easy to get to**, and a further 19% agreed.
- The venue for the TLHC was perceived by attendees as appropriate (75% strongly agreed).
- **Overall experience of the TLHC was good**, with 91% saying they were 'very likely to recommend' the check to others.





Base: All respondents

TLHC patient interviews

We interviewed 21 patients, all of whom had attended a lung health check. They told us that:

Motivations and booking

- Attendees were very conscious and proactive in looking after their health.
- Those who felt in good health and/or has some concerns about past/current smoking were most likely to be motivated to attend.
- Many participants previously had health issues, both lung and other (unrelated) conditions.
- There was some anxiety expressed about receiving results, but did not negate participants booking their slot.
- The booking processes were perceived as efficient and accessible.

Attending

- Appointment was perceived as local and easily accessible.
- TLHC is an efficient service e.g. CT scan could be carried out on the same day.
- The explanations from the staff were easy to understand and digest.
- Some confusion over what parts of lung health were being checked; not understood as a cancer screening; possible 'false sense of security' over other lung issues.

Overall

- Respondents were overwhelmingly positive about all aspects of the check: flexible appointments, professional and clear staff, and easy, non-invasive tests

> The thoughts were, 'I am a smoker and I've been offered a lung check, and it would be a good idea, even if it's a bit scary, to do it'

Targeted Lung Health Check attendee

> It was quick; it was efficient; it was courteous; it was professional

Targeted Lung Health Check attendee

Patient recommendations

1. The TLHC should be promoted more widely.
2. It would be helpful to be prewarned about the TLHC questions they would be asked.
3. Patients would have liked to be able to ask further questions during the TLHC.

Best Practice STT Pathway

We interviewed 3 stakeholders involved in the Best Practice Straight to Test Pathway (STT) project. They told us that:

Aims and benefits

- The fundamental expected benefit for patients is the **shorter time to diagnosis**, often several weeks shorter than in the previous service.
- Respondents were positive about having dedicated roles (Patient Navigator and/or CNS) to **help patients understand the pathway**, set expectations about the speed of the pathway, and provide a consistent point of contact.

Successes

RM Partners were credited with bringing several **key capabilities** to this project. In particular:

- **Strong project management and stakeholder engagement** drove progress in the face of conflicting priorities of different departments. RM Partners is in a potentially unique position to develop and implement collaborations with relevant clinicians and staff from across departments, breaking down clinical silos.
- RM Partners successfully **facilitated information exchange** at the management level as well as across (and between) frontline staff. This helping the CNS to collaborate with other locations who implementing the same pathway.
- **Use of data** was invaluable to plan and 'make the case' for the service, ensuring that it was prioritised. Ongoing data collection was then similarly valuable to implement and monitor the service, including to support business cases, assessment of health inequalities, and the identification of any bottlenecks in the pathway.

> It is about allowing the right person to do different tasks, so freeing up the more senior clinicians to do what they're really much better at doing […] Then you have the ripple effect of the navigator then is able to support the CNS, who then is able to support the doctors

Best Practice Straight to Test Pathway stakeholder

> A lot of people don't understand how processes work within the NHS and exactly how much system work is required beforehand to bring in a completely new way of working. I think people had underestimated just how much input and how many different people were required to be able to bring this together.

Best Practice Straight to Test Pathway stakeholder

Best Practice STT Pathway

We interviewed 3 stakeholders involved in the Best Practice Straight to Test Pathway (STT) project. They told us that:

Enablers

- A **thorough initial triage conversation** with the patient is valuable for both the patient and for effective management of the pathway.
- Smooth operation of the services was supported by a **strong IT-based process** automatically generating referrals and work lists to keep patients moving through the system.
- The original STT bid for funding in one trust suffered from a mismatch between expected and required staffing resources for the intervention. It was suggested that to enable **better quality planning and bids for funding**, it would be helpful to undertake **detailed process mapping earlier in the process** than it is currently undertaken, possibly as the first stage in a two-stage bidding process.
- RM Partners could consider investing resource in this first stage, **bringing together relevant stakeholders to test the intervention concept** in greater detail.

Barriers

- There might be a barrier to full patient involvement if information (and support from patient-facing staff) cannot be provided in **languages other than English**. This might be mitigated by encouraging another family member or friend to assist in these cases.
- It is valuable to **'protect' the Navigator and CNS roles** from being diverted to non-patient-facing administrative tasks.
- Although the relationship between RM Partners and trust worked very well, as they are not 'on the ground', there will always be **limits to how well RM Partners can understand the situation within a particular trust**.

> There's such a move very quickly towards trying to get money agreed that they [bid-writers in the trust] don't necessarily on the shop floor look at what they need to be finding in the first place. […] I think that to a certain extent, they [RMP] almost need to say, 'Right, we'll give you a small amount of money to put the key stakeholders together to see if you can deliver this. If you can, then we will look favourably upon your bid

Best Practice Straight to Test Pathway stakeholder

> Often people on the frontline understand those systems far better and have ideas around how they can make things work more effectively. Yes, so it is about engaging and working with them, and process mapping helps us to understand that.

Best Practice Straight to Test Pathway stakeholder

Practical recommendations

RM Partners is invited to consider…

TLHC	Build on successes in wider TLHC roll-out	• As TLHC is rolled out across a wider area, certain **key elements of success** should be replicated as far as possible. • **Convenience of booking**, **short travel time** to easy-to-find venue, **flexibility of appointments** were all identified by patients as strong positive aspects.
	Review pre-check patient information	• Since some patients identified that in advance of the check they were slightly unclear what tests were being done and why, it may help to **clarify these details in pre-check information to patients**. • Some patients would like to be **able to ask more questions during the check**.
	Alternative approaches for 'harder-to-reach' individuals	• Initial evidence suggests that those attending the TLHC are 'regular attenders' of screening or health checks. • RMP could **gather more data on non-attenders** to understand this group better, and **consider alternative invitation approaches** which target these 'harder-to-reach' individuals e.g. additional phonecalls or emails for these individuals.
Best Practice Straight to Test Pathway	Develop patient information in non-English languages	• Some stakeholders identified a **potential language barrier** to effective operation of the service for some patients. • RMP could develop more **patient information in languages other than English** to limit this issue for certain patients.
	Make the case for dedicated patient-facing roles	• A **key success** of the project is considered to be the **patient-facing CNS and Patient Navigator roles**. However it was suggested that it can be difficult to retain this patient-facing time, with these staff potentially diverted to other activities e.g. admin. • RMP should consider how best to **'make the case'** for protecting these roles.

Monitoring and evaluation

We recommend an **adaptive roll-out approach**. This involves careful monitoring and evaluation of projects, exploring what works, where it works, under what conditions and for which types of patients. Examples of the key questions, data and approaches are included below. More detail including on the approaches and framework are included in the quantitative supplementary pack.

	Evaluation questions	Data to be collected	Quantitative evaluation approaches
TLHC	• What are the costs of the invitation approaches used? • What methods are most effective at increasing TLHC uptake and for which groups? • Are patients being diagnosed with an earlier stage of cancer? • What is the cost effectiveness of different invitation strategies at increasing patient TLHC uptake?	• Costs of the different invitation approaches • The number of individuals invited • The number of patients who respond following invitation/ telephone call • Stage (e.g. initial letter) at which the patient responds to invitation • Patient characteristics (e.g. smoking status) • Baseline scan attendance • Patients diagnosed with cancer and stage of cancer diagnosed • Time to diagnosis	• A comparison of uptake figures using the different invitation approaches, and uptake rates across different patient groups • There is potential for a more sophisticated impact analysis that uses a local control group where the standard approaches to invitation were used • This in order to understand the impact of implementing different invitation approaches e.g. such as a through a difference-in-difference approach
Best Practice Straight to Test Pathway	• Are there any changes in the waiting times for diagnostic services? E.g. delay from X-ray to CT • What is the impact on the proportion of patients meeting the faster diagnosis standard? How does this vary by trust and different patient groups? • Are there improvements to patient experience?	• Number of patients on the STT pathway • Timings of diagnostics • Performance against faster diagnostic standards, including 62 day performance and proportion of patients that have communicated a diagnosis by 28 days • Patient diagnoses, including the number of patients diagnosed with cancer • Stage of cancer diagnosed • Patient experience metrics	• A before-and-after STT project comparison using the key KPIs collected for an initial understanding of the potential impact of the project • A more sophisticated difference-in-difference approach using a control group such as a CCG where STT has not yet been implemented • This more sophisticated analysis is in order to have a more robust understanding of the impact of STT on, for example, waiting times and time to diagnosis

RM Partners
West London Cancer Alliance
Hosted by The Royal Marsden NHS Foundation Trust

frontier economics

50 years NatCen Social Research

NHS

Colorectal pathway – project-specific findings

Overview

FIT

- FIT is a diagnostic tool for patients showing certain symptoms indicative of bowel cancer. The FIT kit can be completed by patients at home.
- A core aim of the FIT test is to allow for effective triage of colonoscopies and prevent patients undergoing this procedure unnecessarily.
- Following the successful NICE FIT study (5000+ patients), FIT has been piloted with patients in Croydon. Following engagement with GPs it was decided that this would be non-mandatory (i.e. GPs could choose whether to participate).

PSFU

- The Personalised Stratified Follow-Up (PSFU) project focuses on aftercare (follow-up) following cancer diagnosis.
- RM Partners is seeking to reduce variation in performance and increase the quality of patient care, by addressing individuals' physical and psychosocial needs.
- This approach is stratified by tailoring the care for different groups, and personalised by allowing flexibility at an individual level within care plans (personalised protocols).
- The project is supported by development of workforce training and digital tools.

Bowel screening

- Bowel screening is a well-established national programme which invites individuals aged 55 and over to be tested (using either a scope screening test or home testing kit, depending upon age).
- RM Partners are working with Community Links, a social action charity in London, to increase uptake of bowel screening by those invited to participate. The project involves Community Links contacting individuals who have not responded, providing more information or reassurance as required, to encourage them to participate.
- Due primarily to information governance issues, implementation of this project was delayed and due to start in early 2020.

Note that due to the timing of project rollout these two projects were not evaluated summatively.

An outline evaluation framework for these projects is included at the end of this section.

FIT kit uptake

- We analysed the FIT data for the first 3 months of the trial.
- Between November 2019 and February 2020, 855 patients took a FIT test. Of these 56% were female and 79% were aged 50 or over.
- Each one of the 50 GP practices in Croydon had at least 1 patient completing a FIT kit, with 17 patients on average per practice over the period.
- There is significant variation in the number of referrals across GP Practices (e.g. Keston Medical Practice referred 82 patients). This in part reflects variation in practices' list size.
- Across all practices, if these rates of referral were maintained for the whole year, it would suggest that around 1% of all patients on a GP list would complete a FIT kit (noting that only a subset of patients would even be considered for FIT). This 1% rate of referral would equate to around 3,800 patients in Croydon per year completing a FIT kit, or around 42,000 patients across West London.
- However, we note that due to the non-mandatory rollout and the relatively short period observed, this number could easily be much higher. If practices referred closer to the 90th percentile of pilot practices, this would rise to 2% of patients completing a FIT kit on average, implying double the number of completed kits and onward referrals.
- We observe geographic differences in bowel screening patterns and lower GI 2WW referral patterns which suggests that FIT kit uptake may also vary across CCGs, and this could be monitored as roll-out continues.

1%

Proportion of all GP-registered patients completing a FIT kit annually if pilot trends maintained

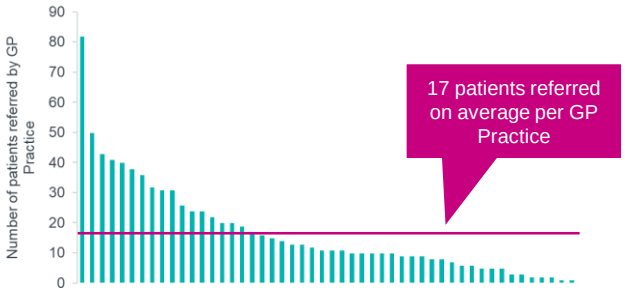
42,000

FIT kits completed across West London annually if pilot trends maintained

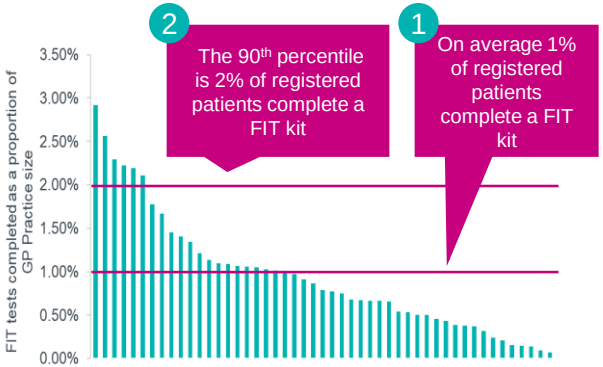
100%

Every GP practice in Croydon had at least 1 patient completing a FIT kit

Patients completing FIT kit by GP Practice



Rate of FIT kits by GP Practice



Source: Frontier based on FIT project data

FIT onward referral and activity

- A core aim of the FIT project is to **increase the quality of referrals** to secondary care and **reduce the number of patients receiving colonoscopies when this could be avoided**.
- Our analysis of the pilot data showed that **29% patients who took a FIT test were referred** to secondary care.
- Older patients taking FIT tests were more likely to be referred: 80% of referred patients on the FIT referral pathway were aged 50 or over.
- Amongst those patients referred, the data indicates that **58% of patients had a colonoscopy** if they were referred to secondary care.
- If these pilot results were maintained for the whole year, it would suggest around 640 patients across Croydon would receive a colonoscopy following completion of a FIT kit. Across West London this figure would be over 7,000.
- Analysis of patient vetting data indicates that the use of colonoscopy and other diagnostic interventions was very similar for patients who had completed a FIT kit and for those who had not. This suggests – at least at this stage of the pilot – little or no impact of FIT on secondary care behaviours.
- This may suggest that **if FIT is to reduce the number of unnecessary colonoscopies, this would occur primarily through avoiding unnecessary secondary care referrals.** Further analysis is required as the pilot progresses and more data is available, including the stage of diagnosis.

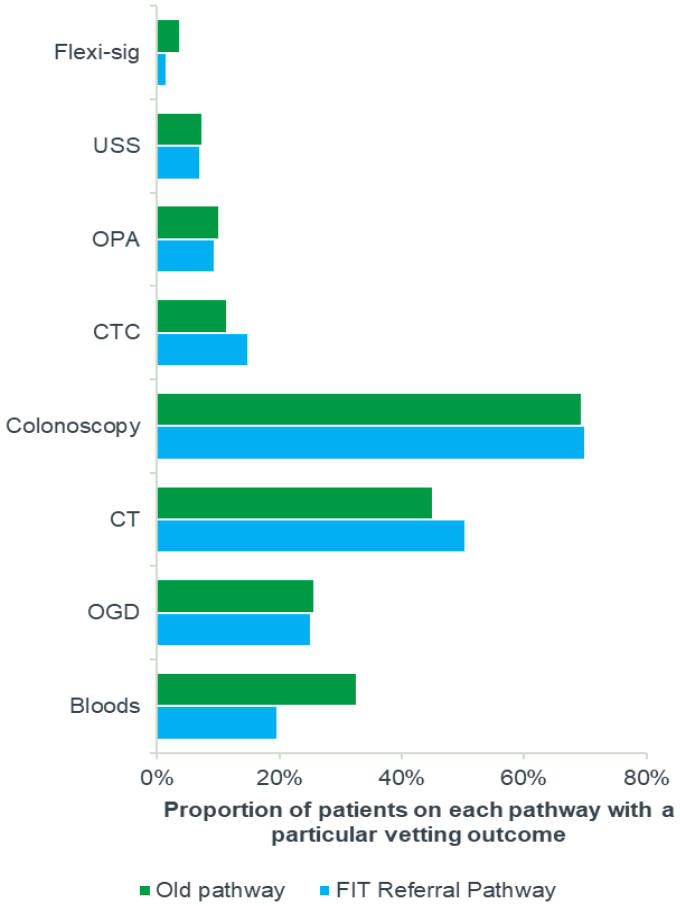
29%

Proportion of patients completing a FIT kit who were referred to secondary care

80%

Proportion of patients referred to secondary care who were aged 50 or over

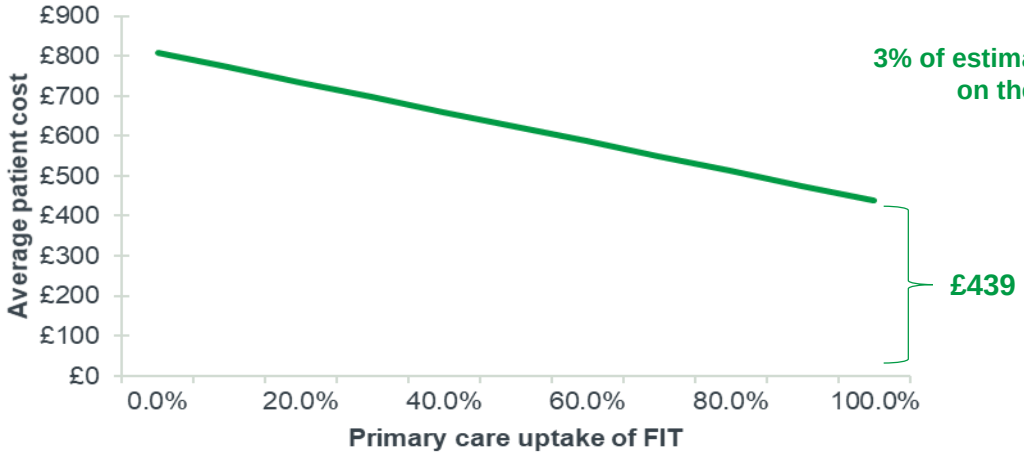
Patient vetting outcomes, with/without FIT kit

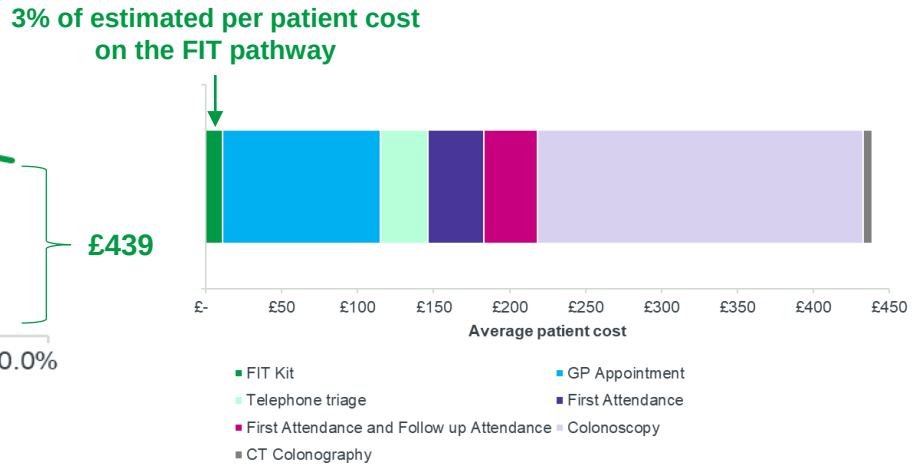


Note: this shows the vetting outcomes and not the actual number of diagnostic activities (e.g. colonoscopies at 58%)
Source: Frontier based on FIT project data

FIT costing and rollout

- The FIT project is being considered for wider rollout across West London. One consideration will be whether there are any economies of scale. We considered previous analysis by the University of York alongside our most recent evidence.
- The York FIT model suggests limited economies to scale with increased patient uptake. This means that **greater GP uptake could lead to a small decrease in the costs per patient to implement FIT**. Most of the costs are driven by patient appointments, and these costs are likely to stay relatively constant regardless of the number of patients referred. However the cost of FIT kits – albeit a small proportion of overall costs – may decline with greater numbers.
- The more significant potential cost impact is the **potential secondary care saving due to reduced referrals and diagnostic activity**. The wider the rollout of FIT, and the higher GP uptake, the fewer patients potentially referred to secondary care overall and undergo diagnostic procedures. The York modelling indicates that colonoscopies account for a significant proportion of patient costs.
- However, the early pilot evidence (presented on the previous slide) suggests that **in order to release these system savings may require a change in GP referral behaviours and/or secondary care clinical processes**. Further work is required to establish whether this would be clinically appropriate and beneficial.





Source: Frontier based on York FIT modelling

FIT staff interviews

We interviewed 3 staff involved in the FIT project. They told us that:

Aims and benefits

- There is a **clear rationale for implementation of the FIT test** with benefits for patients and the NHS, supported by evidence from the NICE trial of 10,000+ patients.
- Stakeholders expect that the FIT project may – in due course – contribute to **earlier diagnoses, greater trust in use of the test, reduction in invasive procedures and thus reduction in patient anxiety**.
- Greater use of FIT may lead to an increase in staff utilisation and provider capacity, owing to reduction in colonoscopies.

Successes

- **Funding and support** provided by RM Partners was critical to deliver the intervention.
- The **governance and reputation** of RM Partners provided confidence locally that the intervention would be robust and successful.

Challenges

- **Concerns were expressed from primary care** that **using FIT for high risk patients** – whom GPs would usually refer straight to a two-week-wait pathway – would mean a **potential delay for these patients**.
- FIT may result in **extra responsibility for primary care** compared to previous referral pathways, whereby responsibility lay with the trust.
- There was **some uncertainty as to ongoing funding**, but steps were being taken to address this issue locally.

> It's only offered to a certain cohort of patients, which are deemed to be low risk. So, these patients are getting a very sensitive test but are at a very low risk of getting cancer, whereas those at high risk are going on a referral pathway which enables - which requires them to do invasive procedures which they might not be fit or suitable for. So, introducing the FIT for all cohorts of patients is one way of reducing that health inequality.

FIT stakeholder

> I think actually the one thing that probably was an unintended consequence, which has come up by clinicians in primary care, is the time delay for when patients who are high risk, they would typically be seen on a two-week wait pathway… It's going to be a consequence that they didn't really consider until now, because it's been raised.

FIT stakeholder

FIT staff interviews

We interviewed 3 staff involved in the FIT project. They told us that:

Barriers

- **Primary care engagement** could have been better, which subsequently acted as a barrier to successful FIT implementation. Stakeholders suggested **GPs should be engaged as early as possible** through meetings, education events, webinars and GP newsletters. This could have been managed in partnership with the Local Medical Committee and the CCG's Variation Team.
- One specific barrier to this engagement was a **perceived focus on commissioner benefit** (through reduction in colonoscopies) amongst some. Communications with GPs were led by the CCG, and perhaps they – with support from RMP – could have demonstrated greater recognition of the impact upon other parts of the system e.g. additional work for GPs.
- Sometimes the scale of the work of RMP, in terms of both geography and its portfolio of projects, led to a perception that they were **not necessarily best placed to understand the detailed local picture**.

Enablers

- **RMP supported commissioners and providers effectively** via funding, leadership, project management support and technical capabilities. These are all important given local resource limitations.
- One respondent also felt that **RM Partner's governance and reputation provided confidence** locally that the intervention would be robust and successful.
- RMP played a valuable role in **information sharing and communication** between partners e.g. sharing results from GP pathology lab.
- Greater **consistent use of technology** across partners would have supported this further e.g. accessing action logs and risk plans through Sharepoint.

> My concern is that with RM Partners, a lot of it is nationally driven at an STP level, without a real understanding of local – or how to manage your local population.

FIT stakeholder

> They've got governance processes. They've got standards that they've got to meet, so you can ensure that if it's led by RM Partners that it's going to follow the correct protocols, and that they're a trusted alliance for us that, when they are delivering it alongside a local Trust, that it will be successful; that you'd hope it would be successful anyway.

FIT stakeholder

Practical recommendations

RM Partners is invited consider…

FIT

Greater primary care engagement

- Given some challenges faced during FIT rollout, RMP should consider **even greater and earlier primary care engagement**, focused on hearing GP perspectives and identifying potential issues as early as possible. This could form a core part of the **wider FIT rollout strategy** and may become easier as PCNs get better established.

Understand the impact on secondary care

- Early indications suggest that whether or not a patient has completed a FIT kit does not make a difference to the diagnostics undertaken in secondary care. RMP should work with trusts to understand how **processes could be refined to make use of the additional information offered by FIT**.
- RMP should gather **more data on GP referral behaviour**, to understand whether use of FIT kits will alter the number referred to secondary care.
- Some GPs also raised the concern that **some patients may face a delay** in accessing the 2WW pathway as a result of completing a FIT kit first, although this was considered low risk by clinicians who designed the intervention. RMP could collect data to confirm that this potential unintended consequence has not materialised.

Close monitoring of uptake and variation

- It would be valuable to gather **more data on FIT activity within primary care**. It would be helpful to explore in more detail the variation in uptake across practices and reasons for this, including possible differences in population characteristics.
- This could **support RMP in increasing uptake**, through greater awareness and support amongst GPs and greater awareness and reassurance for patients.

Measure impact upon colonoscopy activity and costs

- More data and analysis is required to assess whether fewer (or indeed more) colonoscopies are undertaken as a result of FIT rollout. This will impact upon **patient experience and secondary care costs**.
- A potential unintended consequence may be to **increase demands upon primary care**. Data on GP visits and GPs' experiences could be used to test this.

Monitoring and evaluation

We recommend an **adaptive roll-out approach**. This involves careful monitoring and evaluation of projects, exploring what works, where it works, under what conditions and for which types of patients. Examples of the key questions, data and approaches are included below. More detail including on the approaches and framework are included in the quantitative supplementary pack.

	Evaluation questions	Data to be collected	Quantitative evaluation approaches
FIT	• Does FIT leads to a reduction in colonoscopies? • Does FIT increase the burden on primary care? • Are there any changes to patient experience? • Are there any system wide savings from a stage shift in cancer diagnoses?	• GP visits • Referrals to secondary care • Diagnostics in secondary care for usual care and patients on the FIT pathway • Patient experience metrics • Average costs for cancer treatment depending on the stage of diagnosis	• A simple comparison of the data collected to the standard care approach (for which data is also required) • If possible, an impact analysis for each of the questions, such as a difference in difference approach
PSFU	• What is the impact of PSFU on the number of patients are receiving personalised care and support in comparison to business as usual? • What is the impact on the number of consultant clinical appointments?	• Number of patients on PSFU pilot • The number of patients receiving a Holistic Needs Assessment within 31 days of diagnosis and at the end of treatment	• Analysis looking at before and after the implementation of PSFU using the data collected in order to have an initial understanding of the impact on the key metrics • If possible, an impact analysis such as a difference and difference approach for each of the questions
Bowel screening	• What impact does the use of Community links having on patient screening uptake compared to standard approaches? • What is the cost-effectiveness of using Community Links to increase screening uptake?	• Screening uptake and coverage by GP Practices • Number of patients invited to attend screening by patient groups • Community links costs • Cost of standard screening reminder service and GP Practices where this is used	• A before-and-after analysis following the implementation of Community Links in a particular area • An impact analysis such as a difference-in-difference approach • A control group for the impact analysis could be an area where Community Links has not yet been implemented