South West London Health & Care Partnership

MACMILLAN CANCER SUPPORT

NHS

Transforming Cancer Services Team for London

Cancer Community of Practice for General Practice Nurses

Business Case

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Version 2

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Executive Summary

This document outlines the vision and business plan to implement a nurse

led ____________________________________ in____________________________________

Patient Story

A section to include specific patient(s) stories from your practice that you feel would support your business case.

Background Summary

With improved outcomes for people diagnosed with cancer and the increased numbers of those living with and beyond cancer, there is a greater requirement for new models of care that best meet the needs of those who are surviving. Cancer is increasingly seen as a long-term condition and the role of healthcare services outside of hospital is developing. The numbers of people living with cancer continues to grow with a lifetime risk of cancer of 1 in 2 (Ahmad et al 2015)

Additionally, 70% of people with cancer have another long-term condition (LTC) (Macmillan 2015), which reduces survival rates and adds complexity in care provision. The numbers of those with one long-term condition or more is also expected to continue to rise. The average age of those people living with cancer surviving is also predicted to increase with some predictions that by 2040 77% of all cancer survivors will be aged at least 65 years (Maddams et al 2012.) The same researchers project that in 2040 almost one quarter of all people in the United Kingdom aged at least 65 years will be cancer survivors – the equivalent figure for 2008 was one eighth.

NICE (2016) outlines best practice for people living with multi-morbidities and emphasises the importance of an integrated and holistic approach to care. Initiatives to move follow-up care out of hospital (e.g. for prostate cancer) enable an integrated approach to be possible. Primary care led follow up for prostate cancer is business as usual now in many areas of London. It is likely that this approach is likely to be replicated in other tumour types.

However, analysis of patient experience of their care out of hospital reveals many gaps. The National Cancer Patient Experience Surveys (NCPES) repeatedly indicates that people are less satisfied with the ‘out of hospital elements of their care. (insert new data) This outline the challenge ahead of us to improve the experience for people living with and beyond cancer in the out of hospital environment.

Work by the Nuffield Trust on the use of health and social care by people with cancer (2014) demonstrates this patient group use a disproportionate amount of health and social care services after a cancer diagnosis. For example, hospital use remained high for some time after diagnosis. Fifteen months after diagnosis, people with cancer had 60% more Accident & Emergency (A&E) attendances, 97% more emergency admissions, four times as many outpatient attendances and nearly six times more elective admissions than would be expected in a population of the same age/gender. A similar pattern was seen for GP visits, with cancer survivors having 50% more contacts than expected 15 months after diagnosis.

Given that 70% of patients with cancer have another long-term condition the primary care workforce are seeing patients with cancer daily. The nursing workforce specifically has been identified as well placed to meet the needs of this patient group as they typically routinely manage their other long-term conditions. Macmillan describe the primary care workforce as an untapped resource (Macmillan 2013). Knowledge around the needs of those living with and beyond cancer is however variable and with this group of patients growing in number there is an

identified need to develop skills and knowledge. Recent data collected in South West London (2018) indicates that over 70% of General Practice Nurses haven't received any undergraduate/post graduate education or training on cancer apart from cervical cytology training (ref) . The same project has identified examples of good practice with nurses leading the way in cancer care in their practice (ref podcast)

Cancer Prevalence

- National picture
- London
- STP (Sustainability and Transformation Partnership)
- CCG (Clinical Commissioning Group)
- PCN (Primary Care Network)
- Practice

Proposal

____

____

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____

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Mission Statement

This [name] strategy aims to;

- ____
- ____

- ____

Background, Analysis, Rationale

Narrative text – additional to executive summary

____

____

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____

Project Objectives

____

____

____

____

Workforce Implications

____

____

____

____

Estate Impact

e.g. rooms, other resources needed?

____

____

____

____

Goals

Short-term goals:

____

____

____

Long-term goals:

____

____

____

Obstacles – identified risks

____

____

____

SWOT (Strength, Weaknesses, Opportunities, Threats) Analysis

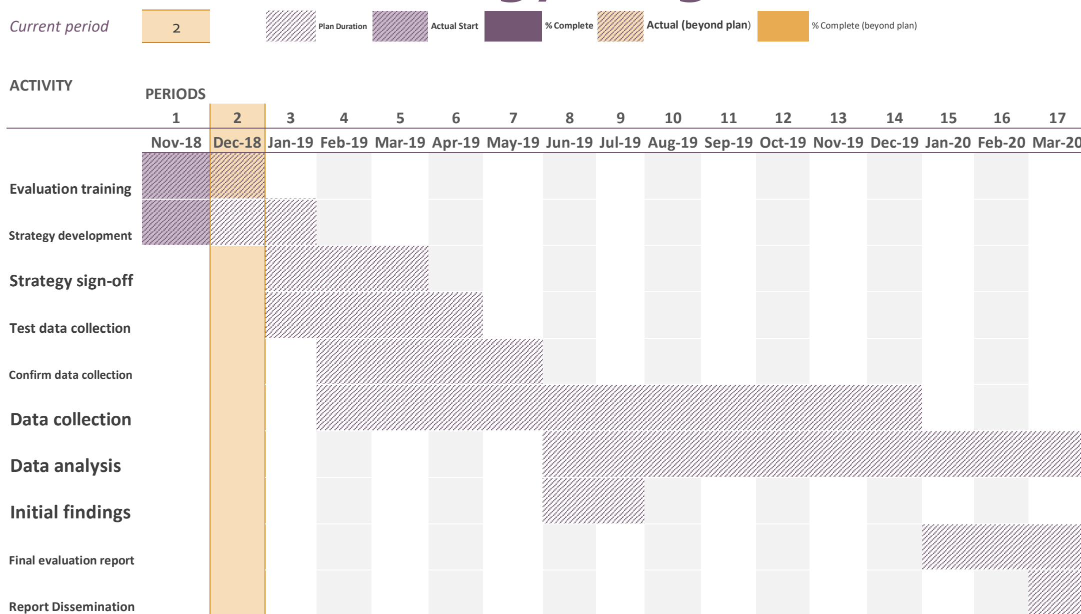
Strengths	**Weaknesses**
• • • •	• • • •
Opportunities	**Threats**
• • • •	• • • •

Implementation (Operational Plan)

Planned activity as part of the proposal, this will include details of how to code / identify patients. How to

- ____
- ____
- ____
- ____

Timeframes for activity (high-level):
(Example Gantt Chart)



Performance, KPIs (Key Performance Indicators), Metrics

The implementation of the strategy will be monitored from date to and from, with project management processes used to track and control progress, with any issues escalated through the appropriate governance channels.

Regular reporting will be delivered through the reporting cycles and processes of

____ , taking place at minimum on a monthly basis.

To support reporting the project team will manage up-to-date information trackers and develop key performance indicators (KPIs). Some examples;

- KPI 1 ____
- KPI 2 ____
- KPI 3____

References

Appendices