Cancer Alliance local evaluation: evaluation framework

NHS England and NHS Improvement

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2019/20 CADEAS resource to support Cancer Alliance led local evaluation

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1 Purpose

This document provides, for the 2019/20 Planning Guidance deliverables (i) strategies to increase screening uptake and (ii) each 'additional deliverable' area:

- A list of potential evaluation questions to be addressed through process, impact and economic evaluations, and
- Corresponding data collection methods and sources.

These resources should be used in conjunction with the wider CADEAS suite of resources, available on the Cancer Alliance Workspace, here.

2 Evaluation framework

The following evaluation questions are not intended as a comprehensive list, nor are Cancer Alliances expected to address all of the questions provided. Cancer Alliances should select, or define, evaluation questions in line with, and to address, local priorities. Please refer to the 'Introduction to approaches to evaluation and data collection reference guide' and the 'Evaluation how to guide' for further information on the development of evaluation questions.

For further details on data sources, please refer to Cancer Statistics: availability and location and the CADEAS signposting guide for Cancer Alliances.

Table One: Demonstrable impact on uptake of the screening programmes

2019/20 Planning Guidance deliverable: Demonstrable impact on uptake of the screening programmes (based on local need), through delivery of project(s) aimed at reducing variation in uptake between different patient groups.			
Questions	**Evaluation approach**	**Data collection methods**	**Data sources**
• What problem is the programme aiming to address? • What is the programme aiming to achieve? • What approach(es) were used to increase screening uptake? • Who was the target population and why were they selected (e.g. geography; age cohorts; specific group)? • What were the barriers and enablers to implementation? • What did staff and participants feel worked, what didn't and why? • What were participant's experience of the programme?	Process evaluation	• Review of programme documentation. • Bespoke qualitative and quantitative data collection - surveys, interviews and, or, focus groups of staff and patients to understand what works and what doesn't; and, or, of patient experience.	

• What impact has the programme had on:
   • take-up rates;
   • detection of cancer (detection rates);
   • stage of diagnosis;
   • survival;
   • service demand and activity locally (including on Cancer Waiting Times);
   • patient experience and
   • reducing variation and inequalities (e.g. access, uptake or outcomes)?
	Impact evaluation	• Routinely collected data	Screening uptake and coverage (CancerStats2; various official statistics – see CADEAS signposting guide)
			
			Routes to diagnosis
			
			Stage of diagnosis

			Survival National Cancer Patient Experience Survey Cancer Waiting Times
		• Bespoke quantitative data – survey; data collection on activity and participants.	
• What were the costs of the programme (for example costs of awareness campaign and, invites, reminders; increased screening costs from higher uptake; bringing forward and potential changes in treatment costs from earlier diagnosis? • What were the benefits or savings (for example potential changes in treatment costs from earlier diagnosis and improved quality of life (quality adjusted life years (QALYs))? • Do the benefits or savings from the programme outweigh the costs?	Economic evaluation	• Routinely collected data e.g. unit costs.	Average cancer incidence costs per patient for breast and colorectal cancers by stage NHS reference costs Unit costs of health and social care
		• Bespoke quantitative data, e.g. activity metrics.	

Table Two: Time to diagnosis

2019/20 Planning Guidance deliverable (additional deliverable): Demonstrable improvement in numbers of patients diagnosed in 28 days on other pathways (based on local need).			
Questions	**Evaluation approach**	**Data collection approach**	**Data sources**
• What changes were made to pathways? • What changes were made to existing processes to improve flow (e.g. booking of tests, patient tracking, management by MDT, approaches for communicating diagnosis to patients)? • What changes were made to resources (people; skills and, or, equipment)? • How were the changes made including teams involved and interaction between teams, for example, between primary and secondary care and diagnostic teams and consultants? • What were the barriers and enablers to implementation? • What did staff and patients feel worked, what didn't and why? • Were there any parts of the pathway that caused more difficulties or were more challenged? • What lessons learnt are applicable to other tumour sites? • Have there been any issues or barriers to recording or measuring the standard?	Process evaluation	• Review of pathway models. • Bespoke qualitative and quantitative data collection - surveys, interviews and, or, focus groups of staff and patients to understand what works and what doesn't; and, or, of patient experience.	

• What changes were observed on:
  • time from referral to when a diagnosis was recorded for the tumour site/pathway and other (related) tumour sites/pathways;
  • other Cancer Waiting Times standards;
  • referrals, activity, resource use, capacity and costs;
  • flow of routine and, or, urgent referrals; and
	(Monitoring)	• Routinely collected data.	Cancer Waiting Times System – Faster Diagnosis Standard (internal)
			
			Official statistics – Cancer Waiting Times; Diagnostic Waiting Times

• patient experience?			[Distribution of time to first treatment by tumour groups](#) (internal management information produced by NHSE&I OIC and CADEAS) [National Cancer Patient Experience Survey](#)
		• Bespoke quantitative data – activity; resource use; capacity; patient experience.	

Table Three: Interventions to implement protocols for personalised follow-up for prostate and/or colorectal cancer patients

2019/20 Planning Guidance deliverable (additional deliverable): A. Full implementation of protocols for prostate and/or colorectal patients – approximately half of patients who finish treatment for colorectal or prostate cancer to be on a supported self-management follow-up [1]pathway (SSMFU).			
Questions	**Evaluation approach**	**Data collection approach**	**Data sources**
- Were protocols for prostate and/or colorectal patients implemented as planned? - Which of the following are available, to who and when in the patient pathway: - Holistic Needs Assessment; - Personalised care and support plan; - End of treatment summaries; - Cancer care reviews; - Health and wellbeing information and support including psychological care; and care for, or prevention of, other consequences of treatment; - systems to re-access the service; and - IT systems to enable specialists to schedule and monitor routine surveillance tests? - How were the above implemented and what were the barriers and enablers to implementation? - What did staff and patients feel worked, what didn't and why? - Are there any lessons that are applicable to other tumour sites? - Were there any parts of the pathway that caused more difficulties or were more challenged? - Is a copy of the patient's treatment summary provided to the patient and GP?	Process evaluation	- Review of pathway models and project documentation. - Bespoke qualitative and quantitative data collection – surveys, interviews and, or, focus groups of staff and patients to understand what works and what doesn't; and, or, of patient experience. - Bespoke quantitative data collection – surveys.	

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[1] Self-management is a term used to include all the actions taken by people to recognise, treat and manage their own health. They may do this independently or in partnership with the healthcare system.

• Are clinicians aware of availability of clinical and non-clinical support services and how to refer e.g. psychological support; physical activity schemes and benefits advice? • Are patients aware of the support services available to them? *Also see questions in part B below.*			

• What impact have the protocols had on:
   • resource use (e.g. clinical time);
   • patient experience;
   • patient quality of life;
   • faster and earlier diagnosis (recurrence; freeing up resources); and
   • survival?
	Impact evaluation	• Bespoke quantitative data collection (e.g. resource use; please also refer to draft LWBC metrics and data collection definitions).
		• Routinely collected data.
			National Cancer Patient Experience Survey
			
			Cancer Waiting Times
			
			Survival

• What were the costs of the programme (for example costs of interventions and systems; programme management; clinical time; bringing forward and potential changes in treatment costs from earlier diagnosis)? • What were the benefits or savings (for example clinical time; potential changes in treatment costs from earlier diagnosis and improved quality of life (quality adjusted life years (QALYs))? • Do the benefits or savings from the programme outweigh the costs?	Economic evaluation	• Routinely collected data e.g. unit costs.	Average cancer incidence costs per patient for breast and colorectal cancers by stage NHS reference costs Unit costs of health and social care
		• Bespoke quantitative data – data collection on activity.	

2019/20 Planning Guidance deliverable (additional deliverable): B. Develop clinically agreed personalised stratified follow up protocols and remote monitoring in other, clinically appropriate, cancer type(s).			
Questions	**Evaluation approach**	**Data collection approach**	**Data sources**
• Who is the target population and why? • Who was involved in developing the protocol (stakeholders/project team)? • What resources were required to develop the protocol? • How was consensus on how the system will work operationally agreed between clinicians, managers and commissioners? • What are the stratification criteria and process? • What is the remote monitoring system and how will it be implemented? • How does the protocol support re-access for patients to the service when problems arise? • What changes are expected on demand and service use from clinical efficiencies in implementing the protocol (GP care; urgent care; outpatient appointments; staff capacity)? • What changes are expected on outcomes e.g. patient experience; quality of life; recurrence? • What were the challenges and enablers to developing the protocol? • How will implementation of the protocol be monitored and evaluated, and findings shared/reported?	Process evaluation	• Review of protocol developed and related project documentation. • Bespoke qualitative data collection - interviews and/or focus groups of staff.	

Table Four: Personalised care interventions

2019/20 Planning Guidance deliverable (additional deliverable):
• Make the following available to patients with cancer types other than breast, prostate and colorectal: Holistic needs assessment, personalised care and support plan, end of treatment summary and health and wellbeing information and support.
• Improve access to psychological care (all cancers).
• Improve access to care for/prevention of other consequences of treatment (all cancers).
• Improve quality of cancer care reviews.

Questions	Evaluation approach	Data collection approach	Data sources

• What changes (e.g. to resource; pathways) have been introduced to offer a more personalised approach to care, both in terms of access and quality? How? Have these been implemented as planned?
• Which of the following are available, to who and when in the patient pathway:
   • Holistic needs assessment;
   • Personalised care and support plan;
   • End of treatment summaries;
   • Cancer care reviews; and
   • Health and wellbeing information and support including psychological care; and care for/prevention of other consequences of treatment.
• What are patients' and staff views on cancer care reviews?
• What were the barriers and enablers to implementation?
• What did staff and patients feel worked, what didn't and why?
• Are clinicians aware of availability of clinical and non-clinical support services and how to refer e.g. psychological support; physical activity schemes and benefits advice?
• Are patients aware of the support services available to them?
	Process evaluation	• Review of pathway models and project documentation.
		• Bespoke qualitative and quantitative data collection – surveys, interviews and, or, focus groups of staff and patients to understand what works and what doesn't; and, or, of patient experience.	

• Do patients feel the services have helped with their connection to the community?			

• What impact have the changes had on:
  • take-up and offer of:
    ▪ Psychological care;
    ▪ Access to care for/prevention of other consequences of treatment; and
    ▪ Cancer care reviews?
  • patient experience
  • patient quality of life
	Impact evaluation	• Bespoke quantitative data collection (e.g. resource use; please also refer to draft LWBC metrics and data collection definitions).
		• Routine quantitative data collection.
			National Cancer Patient Experience Survey

• What were the costs of the programme (for example costs of interventions and systems; programme management; clinical time; bringing forward and potential changes in treatment costs from earlier diagnosis)? • What were the benefits or savings (for example clinical time; potential changes in treatment costs from earlier diagnosis and improved quality of life (quality adjusted life years (QALYs))? • Do the benefits or savings from the programme outweigh the costs?	Economic evaluation	• Routinely collected data e.g. unit costs.	Average cancer incidence costs per patient for breast and colorectal cancers by stage NHS reference costs Unit costs of health and social care
		• Bespoke quantitative data – data collection on activity.	