social care
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MACMILLAN
CANCER SUPPORT

Learning from the Macmillan Local Authority Partnership programme

December 2020

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About SCIE

The Social Care Institute for Excellence improves the lives of people of all ages by co-producing, sharing, and supporting the use of the best available knowledge and evidence about what works in practice. We are a leading improvement support agency and an independent charity working with organisations that support adults, families and children across the UK. We also work closely with related services such as health care and housing.

We improve the quality of care and support services for adults and children by:

- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy.

First published in Great Britain in December 2020 by the Social Care Institute for Excellence

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Introduction

This guide focuses on implementing system change in cancer care by drawing on the experience of the Macmillan Local Authority Partnership (MLAP) programme. The guide supports leaders, commissioners and practitioners from health, social care, housing, and voluntary and community sector organisations to implement a person-centred, integrated approach to providing care and support to people affected by cancer (PABC). It can also be used to supported people affected by other long-term conditions (LTCs).

The MLAP programme aimed to ensure that everyone diagnosed with cancer can easily access the cross-sector integrated support they need, to enable them to live their lives as independently as possible. Four partnerships, Dundee, Fife, Durham and Tower Hamlets, participated in the programme to March 2020 and each received funding from Macmillan Cancer Support (Macmillan) to enable them to develop a local MLAP.

Macmillan commissioned SQW and the Social Care Institute for Excellence (SCIE) to undertake a three-year independent formative evaluation of the MLAP programme. The evaluation concluded in March 2020 and the findings have informed this guide. The guide describes several broad steps and practical actions to consider, and it is up to you and your colleagues to determine which actions you choose to pursue and in what order.

It is important to note that the evaluation of the programme ended just before the outbreak of COVID-19 in the UK, and therefore does not describe or reflect on how to implement this programme during the pandemic. However, the insights and actions set out in the guide should still be useful to those implementing partnership programmes aiming to improve the lives of PABC.

In England, this vision for more personalised care for PABC is supported by the NHS Long Term Plan which seeks to make personalised care 'business as usual' across the health and care system, with 2.5 million people benefiting from the Comprehensive Model for Personalised Care by 2023/24.

In Scotland, the Government produced a cancer strategy in 2016 that included a commitment to:

> *'Invest £9 million over five years to support access to health and social care services during and after treatment, via, for example, link workers to provide support in the most deprived communities and initiatives such as Macmillan's Improving the Cancer Journey.'*
>
> Beating cancer: ambition and action **(Scottish Government)**

In 2019, the Scottish Government and Macmillan launched an £18 million partnership to roll out the ICJ/MLAP model across the country.

MLAP programme in Fife

This guide should be viewed alongside the **video** of how the MLAP programme has been delivered in Fife.

Key messages

- There is no set way to implement system change in cancer care. Instead, learning from programmes such as MLAP, the local context and previous experience should shape the design, development and delivery of any new service model.
- Local areas should consider undertaking partnership-wide visioning exercises to generate buy-in and provide clarity about the purpose and aims of the MLAP in each site, ensure the vision remains well aligned and to monitor progress towards its achievement, in order to sustain engagement and ensure progress remains on track.
- Establishing a programme board made up of senior representatives from a range of organisations committed to and championing the MLAP is key for providing strategic direction and overseeing delivery.
- The recruitment of a programme manager with a specific set of skills, as well as sufficient and qualified support staff, should be an early priority.
- Project timescales should allow for scoping activities such as mapping the cancer landscape, assessing existing assets in the community and cancer care pathway modelling.
- Any programme should be rooted in a co-production approach with people living with cancer and carers/families, with shared commitment from the top, a clear vision, strategy and delivery plan for co-production activities and dedicated resources.
- Effective partnership working is needed at the strategic and project delivery levels, by facilitating commitment of all partners, clearly identifying partners' roles and responsibilities, and encouraging mutual respect and sensitivity.
- Making time for shared learning is key when implementing system change programmes. This involves building new relationships and implementing new ways of working.
- Planning should include consideration of timelines and thinking about how long elements of the project can take; and adding contingency in the schedules for delays.
- To sustain co-production, it is important to plan meaningful and genuinely productive activities for co-production volunteers to work on so that they feel engaged and are making a meaningful contribution.
- Working closely with the local voluntary and community sector (VCS) will maximise potential impacts for PABC. Given the funding and capacity pressures and concerns of the VCS, it is important to ensure any impact of an MLAP on the VCS is understood and effective partnerships with the VCS to support PABC are built.
- Sustaining services requires flexibility to respond to national and local policy and service changes

About the MLAP programme

Started in 2015, the MLAP programme aimed to provide clear, seamless and accessible pathways of care and support for people living with cancer, based on a robust, holistic assessment of individual need. Four partnerships, Dundee, Fife, Durham and Tower Hamlets, participated in the programme to March 2020 and each received funding from Macmillan to enable them to develop a local MLAP. The programme has sought to embed co-production with PABC and their carers from the very beginning.

The MLAP programme seeks to respond to the changing nature of cancer in the UK, with growing numbers of PABC requiring holistic, community-based support.

For example:

- there were an estimated 2.5 million people living with cancer in the UK in 2015, and this is projected to rise to 4 million by 2030
- the incidence of cancer has risen such that nearly one in two people will contract the disease in their lifetime.

These incidence and prevalence statistics are partly due to increased survival and life expectancy. Advances in treatment mean that people with cancer are now living longer. Whilst it is welcome that more people are now surviving cancer, for these people the consequences of the disease have an impact not only on their physical condition, but also their psychological, social and financial functioning.

The needs of PABC can vary greatly, depending on their cancer journey stage, demographic characteristics, socio-economic status and a range of other factors. One Macmillan study that looked at the social care needs of people with cancer found they required significant levels of support with their emotional needs, mobility, practical tasks, medical appointments, personal care and looking after dependents.

Currently, there is a shortage of high-quality personalised care and support for PABC. This includes a lack of understanding from social services and cancer services of the wider needs of cancer survivors beyond their healthcare needs. In 2010, 90 per cent of people with cancer were not referred for assessment by social services within three months of diagnosis. There is also:

- A lack of awareness among health, social care and VCS professionals of other existing services, eligibility criteria, what is provided and how to refer or advise PABC to access them
- A corresponding lack of awareness among PABC of existing services and criteria for receiving help

- A lack of integration within health and social care (particularly outside Scotland), which may make it harder for PABC to navigate both systems and receive the support they need
- The context of constrained resources and growing demand, which may limit capacity to provide services for PABC

Cancer is therefore a social issue as well as a medical one.

The MLAP programme sits within a wider drive across the UK to integrate health and social care services, deliver more personalised care and support people with long-term conditions (LTCs). In England, integrated care systems (ICSs) involving local health and social care partners are being established to take collective responsibility for the health of local populations. In Scotland, since 2015 health and social care partnerships have taken responsibility for planning joint health care and single budgets.

The MLAP programme builds on two Macmillan flagship approaches:

The Recovery Package

The Recovery Package identifies and addresses the changing needs of people living with cancer from diagnosis onwards, so that their care is person-centred and their health and wellbeing needs are supported.

The package aims to enhance integration between primary and secondary care settings and the local community, as well as encouraging self-management. This should reduce the need for follow-up appointments for non-complex cases, improve efficiency of health and care professionals' time, relieving pressure on the system and improving the experience of people with cancer. It means people with more manageable needs can be supported by the community, professionals or trained volunteers.

This model helps people with cancer to live as well as they possibly can and improves their outcomes through:

- **holistic needs assessments (HNA) and care planning** – helping to identify their physical, emotional, practical and financial needs and looking at how these could change in the future. It also uses an individual care plan to set out any actions they, or those caring for them, have taken or will take to address their needs
- **treatment summary** – a simple summary of the treatment received is shared with the person with cancer and their GP practice, so both are aware of the potential short- and long-term consequences of the treatment. This eases the person's transition between hospital and community settings. It also helps to ensure any future issues are identified and addressed promptly
- **cancer care review** – through the treatment summary this should provide the person living with cancer with ongoing opportunities to have a conversation with someone from their GP practice, so they can build a new support network and raise any concerns they may have via a cancer care review
- **health and wellbeing events** – to prepare the person for the transition to supported self-management. The event should include advice on relevant consequences of treatment, how to recognise issues and who to contact. They should also provide information and support on work, finance, healthy lifestyles and physical activity.

The Recovery Package is recognised in the NHS England Five Year Forward View and the Cancer Taskforce Strategy, which outlines a commitment to ensuring that 'every person with cancer has access to the elements of the Recovery Package by 2020'.

The Improving the Cancer Journey initiative (ICJ)

The Improving the Cancer Journey initiative (ICJ) in Glasgow, a Macmillan partnership programme which invites every newly diagnosed individual with cancer to an appointment with a link worker based in a community setting or hospital-based clinic. Clinical professionals in secondary and primary care can also make referrals. The link workers conduct HNAs where they discuss and identify people's support needs and co-produce a care plan (which is shared with the relevant professionals) and people are enabled to access support to help to meet their needs.

The MLAP programme involved:

- creating clear pathways designed around individuals and streamlined for convenience, efficiency and accessibility
- mapping the assets available, identifying gaps and building on existing links in local communities
- ensuring cancer support is embedded in strategic planning
- focusing on holistic care needs when commissioning services
- co-production by involving people living with cancer: this is a fundamental element in shaping the design and delivery of the programme.

MLAP activities take place at three levels, with each level feeding into the next:

1. **Partnership working and system change** – establishing a partnership and working through this to create service and system change.
2. **Team and service development** – establishing a structure and service/pathway through which to undertake HNAs and support people living with cancer to obtain access to and/or navigate the support and services they need.
3. **HNAs and associated activities** – such as care plans and care navigation.

Three strands or levels in the Macmillan Local Authority Partnership programme

1. **Partnership and system change**
2. **Teams and service development**
3. **Community HNA**

Data from HNA

An MLAP has **two phases**:

- **Phase 1** – establishing the partnership and identifying the needs of people living with cancer, focusing on mapping local assets (services/support available) and gaps in services, and developing a delivery plan.
- **Phase 2** – focuses on the delivery of the plan and establishing the sustainability of the work in the longer term.

What are HNAs and care plans, and how do these help?

A holistic needs assessment (HNA) helps to ensure that physical, practical, emotional, spiritual and social needs are met in a timely and appropriate way, and that resources are targeted to those who need them most. An HNA is a simple questionnaire that is completed by a person affected by cancer (PABC). This simple yet powerful tool organises needs into overarching categories and covers over 60 areas of concern. It allows PABC to highlight the critical issues that matter to them at that time, which in turn informs the development of a care and support plan with their link worker (or other relevant person such as their nurse). The questionnaire can be completed on paper or electronically.

Undertaking an HNA supports the broader aim of ensuring people receive personalised care that reflects their specific health and care needs. It can make a big difference to people's experience of care – for example, by helping them realise that their concerns are worthy of consideration and not unusual. The conversation itself can be very therapeutic for people and can identify their own strengths and coping skills so that they don't feel powerless in managing their condition. Additionally, involving people in making decisions about their care and health needs recognises their role as experts in their own lived experience, and gives them choice and control over the services they receive.

Improving outcomes

A MLAP is intended to transform care and support for PABC. Key intended outcomes are:

For people living with cancer and carers/families

- more control and opportunity to voice and meet their concerns
- reduced anxiety and improved confidence
- a greater understanding of the support available
- increased wellbeing
- making a contribution to community assets
- reduced social isolation
- feeling well supported
- having a personal record to reflect on.

For professionals

- increased knowledge, skills and confidence
- increased job satisfaction and quality of care.

For services

- integrated and seamless pathways for PABC
- reduced duplication and delays
- increased staff skills, knowledge and confidence
- increased efficiency and cost-effectiveness.

Overview of the four MLAP sites

Dundee

Macmillan and Dundee City Council launched the Dundee Macmillan Improving the Cancer Journey service in November 2017. The success and learnings from Macmillan's Improving the Cancer Journey in Glasgow (ICJ) initiative as well as Macmillan's Transforming Care After Treatment (TCAT) programme were a major influence on the development of the MLAP in Dundee. The programme uses holistic needs assessment and collaborative care planning to provide practical, personal and emotional support to people affected by cancer. This allows the team to focus on what matters most to the individual, whether money and finances, getting practical help at home or coming to terms with the emotional impact of cancer.

MLAP journey so far:

- service delivery began November 2017
- everyone with a cancer diagnosis in Dundee is invited to receive an HNA, ensuring equity via a letter from Information Services Division (ISD)
- health and social care professionals in primary and secondary care and the voluntary sector can make referrals, as well as individuals being able to self-refer
- 465 people who use services (to end of 2019); 5 per cent of service users were carers
- most common concerns raised related to money, tiredness, and moving around
- average number and severity of concerns fell from first to second HNA (and the reductions were statistically significant, although without a comparator it is not possible to definitively attribute the reductions to the service)
- health and wellbeing events led by the co-production group brought clinical and community services together
- identified a need for peer-to-peer support and funded a pilot with Dundee Volunteer and Voluntary Action.

Durham

Macmillan and Durham County Council developed a new service, Joining the Dots, which officially launched in January 2019. The service is being delivered by a provider that is a partnership between the local NHS foundation trust and a VCS sector organisation. Six facilitators (equivalent to link workers) work across County Durham, conducting holistic needs assessments and using collaborative care planning to ensure that a person's

financial, emotional, practical and spiritual needs are met, whilst clinical services are dealing with physical elements of the person's care.

MLAP journey so far:

- service delivery began in January 2019
- referrals are received from clinical nurse specialists, GPs, Macmillan Information Centres, community venues and all cancer support services, as well as people affected by cancer being able to self-refer
- 503 service users (to end of 2019); 16 per cent of service users were carers
- most common concerns raised related to money, worry/fear/anxiety and housing
- a co-production group was formed that both identified problems for local PABC and designed the model for supporting people
- commitment from Durham CCG to ongoing funding.

Fife

Macmillan and Fife Health and Social Care Partnership launched the Fife Macmillan Improving the Cancer Journey service in September 2018. The service was informed by the Glasgow ICJ initiative as well as Macmillan's TCAT programme. The programme uses holistic needs assessment and collaborative care planning to provide practical, personal and emotional support to PABC. Provision of holistic care, integrated delivery and reduction of health inequalities were key aims.

MLAP journey so far:

- 1.5 local area coordinators transferred from TCAT to ICJ
- service delivery commenced September 2018
- 566 service users (to end of 2019); 5 per cent of service users were carers
- most common concerns raised related to tiredness, moving around, eating and sleep, followed by money
- average number and severity of concerns fell from first to second HNA (reductions were statistically significant, but definitive attribution to the service is not possible)
- introduction of community venues for HNAs.

Tower Hamlets

The Tower Hamlets MLAP is a transformation programme. Its main focus is to ensure delivery of personalised care and support seamlessly across sectors to meet the wider holistic needs of people living beyond cancer through system-wide changes in culture and practice.

This programme has significant interdependencies with transformation programmes in Tower Hamlets looking to improve access to information, advice and guidance, care coordination and navigation, and social prescribing. The programme intends to enable people to live as

well and as independently as possible and to support their carers. It launched in February 2018.

MLAP journey so far:

- good links established with other transformation bodies, initiatives and professionals
- comprehensive asset map
- cancer health intelligence report
- insights from 48 residents affected by cancer
- co-designed holistic support pathway, developed a series of ‘change ideas’ and functions required to deliver personalised care
- facilitated delivery of training on ‘cancer as a long-term condition’ to cross sector workforce.

Initial project planning and engagement

Each MLAP site spent an initial period of time building strong foundations to ensure that the programme would run successfully.

Key activities included:

- engaging with PABC, carers and families to establish their priorities and aspirations for local services, and engaging them on how they could get involved in co-production
- being clear about shared goals and other aspects of the partnership. This is important in building strong partnerships and allowing flexibility in delivery to meet joint aims
- mapping out key strategic stakeholders who have either a direct role in delivering the programme or direct influence on its success
- communicating with all relevant stakeholders about the vision for the programme, and how to get involved and support it
- establishing a project team to deliver the programme, including staff with skills in delivering local cancer care services, project management, data analysis, communication, information and advice
- mapping local assets, identifying gaps in support and identifying potential synergies with other services and initiatives.

Establishing the programme board

The MLAP process

Any programme should be overseen by a programme board comprising senior representatives from a range of partners and stakeholders, including the local authority, health services, social care services, voluntary and community organisations, Macmillan, PABC, carers and wider communities. In some of the MLAP sites, the housing sector is represented on the board and it is recommended that they be seen as key stakeholders.

The board is a key entity, expected to provide overall strategic direction to the MLAP. It oversees the development and delivery of the new service, financial governance and monitoring. It reviews progress, and oversees risk and issue management, among many other duties and responsibilities. The board is also responsible for championing and advocating the programme, securing buy-in from stakeholders and removing barriers where necessary.

The evaluation found that partnership working can start quicker and be more effective in established partnership systems, where existing relationships between partners are often stronger and less early 'familiarisation' work is necessary. For example, existing integrated partnerships, such as the integrated joint boards in Scotland, have proved to be a very useful vehicle for the engagement and input of stakeholders. Therefore, it is helpful when thinking through how the board should be structured and its membership, to see if there are opportunities to build on strong existing partnership arrangements.

Setting up a programme board or influencing existing governance can be time consuming and difficult, as local partners often have conflicting projects and priorities. Similarly, it can be difficult to ensure the board has the right mix of individuals with a shared interest in and passion for the programme. It is also critical to ensure board members receive support and training, and have sufficient time to carry out their responsibilities (all involved partners will be dedicating their time to this board or programme as an add-on to their existing roles/functions).

Learning from MLAP sites has indicated that **having a 'champion' in a senior representative role** can facilitate engaging with partners and setting up a dedicated board

or influencing existing governance. For example, the champion might be the chief executive of the local authority, a local councillor or a director of public health. Such senior representation and buy-in can help to secure support and engagement from key individuals and partner organisations as well as expanding the awareness, influence and reach of the programme.

> *'We had committed political leadership from the beginning. Our lead member for adults and health care has been committed to building a personalised approach to supporting people with cancer from the beginning, and has stayed the course, encouraging people to continue to support the programme.'*
>
> **Programme manager**

One of the first roles of the board should be to develop a compelling, and widely-owned, vision for action. All of the sites benefited from taking the time and investing effort in developing a compelling and widely-owned vision for personalised, asset-based care and holistic support for PABC and carers for the local area. This should set out the context for the vision, the outcomes sought, and how the initiative will deliver these outcomes. As discussed later, this should be co-produced with PABC and carers.

More specifically, local areas should consider undertaking **partnership-wide visioning exercises**. This proved key for generating buy-in and providing clarity about the purpose and aims of the MLAP in each site. We recommend that any future partnerships undertake this exercise. Reconvening, perhaps on an annual or six-monthly basis, to ensure this vision remains well aligned, and to monitor progress towards its achievement, may also prove useful in sustaining engagement and ensuring progress remains on track.

Things to consider

- Build sufficient time into the project plan to set up a dedicated and efficient programme board or draw on and influence existing governance
- Deliver a series of visioning events to ensure that a wide range of local stakeholders have contributed to, and feel ownership over, the vision
- Identify a 'champion'/senior level buy-in to support and thereby help to move the programme along.
- Develop a clearly articulated rationale and aim(s) which clearly set out each partner's role and what they are expected to contribute, as this helps to ensure their continued engagement with the partnership
- Ensure there are clear terms of reference for the board that are agreed by all members.

Top tips

- Ensure that there is clear alignment between the programme plans and other relevant local strategies and plans, such as integrated care plans. Establish that the programme can help support the delivery of existing strategic priorities (e.g. integrated care systems or sustainability and transformation partnership systems plans in England)
- Communicate to partners how the programme fits within and adds value to their existing remit

- Meet with partners on a one-to-one basis several times to build personal relationships and secure buy-in
- Identify and work with any local bodies that have widespread reach and good relationships with potential partners and stakeholders
- Involve the programme board at regular intervals to ensure commitment is maintained.

Key resources

- Achieving integrated care, Best practice actions (LGA and SCIE, 2019)
- See Annex 2 for the terms of reference for the programme board in Dundee
- How to work together to achieve better joined-up care (SCIE, 2019)

Recruiting programme managers and organising workstreams

Learning from the sites has indicated that recruiting for the role of programme manager is an important priority. There can be challenges in finding the right person for the post, and for some of the MLAP sites this led to lengthy delays in the start-up of the programme.

The role requires:

- excellent strategic influencing skills
- knowledge and experience of working across organisations and with different professions
- good programme and project management skills
- excellent communication, engagement and facilitation skills
- an understanding of cancer and its impact on people living with the condition and their families
- knowledge of commissioning and budget management
- experience of working with seldom-heard groups
- awareness and understanding of sustainability
- understanding and commitment to demonstrating outcomes.

Challenges can include agreeing roles and responsibilities, reporting arrangements and seniority, to name but a few.

It is important that the programme manager feels supported in their role. The sites emphasised the importance of recruiting support staff with clear remits. This included business support officers, programme coordinators and user involvement facilitators.

Organising the delivery of the programme requires operational teams. Many sites have tended to organise around five to seven workstreams, generally focusing on:

- co-production/user involvement
- asset mapping and gap analysis

- development of a service delivery model
- maximising income – welfare and benefits
- evaluation
- data-sharing/information governance
- communications and marketing
- equality impact assessment.

Durham – Importance of finding the right programme manager

In Durham, the programme manager came with strong experience of networking on challenging issues across different organisations, which proved useful to the early stages of bringing partners together, scoping the problem and designing a solution. When the service was up and running, the site appointed a replacement postholder (with the initial one taking up a new role in the local authority but maintaining strategic oversight) with experience of service delivery to manage the service that had been designed.

Ideally, each workstream should have a senior lead, and often board members act as the leads for individual workstreams. This helps to ensure that board members are closely involved on an ongoing basis in the delivery of the programme and that each workstream receives strategic direction. In other instances, steering groups oversee workstreams and report back to the board on their progress. This works in local contexts where boards do not have the time to oversee operational work.

The sites have identified the existence of a strong team, as described above, as essential to supporting the programme manager and thereby driving the work forward.

Things to consider

- Consider planning for recruitment earlier in the process, mindful of the potential time lags often associated with recruiting key staff, and associated delays with mobilisation.
- Recruit a dedicated programme manager at an early stage of the programme.
- Provide programme managers access to relevant support staff – any programme requires a lot of focus on engagement and coordination of stakeholders and partners, whilst also managing and driving the work forward.
- Workstreams should develop delivery plans, including timescales and key milestone outputs, and these should be signed off by the board.
- Create a clear governance structure and reporting arrangements for multiple bodies such as the board, steering groups and workstreams.
- Create a risk log/register to ensure that each workstream is able to tackle issues and challenges as and when they arise, and to monitor the progress and effects of mitigating actions.

Top tips

- Find the right person for the programme manager post – this is very important and can take time.

- Include at least one PABC on the interview panel for the programme manager role.
- Pitch the programme manager role at the right level of seniority and salary band, with an appropriate title and clearly identified skills and responsibilities.
- Look for skills and responsibilities like strong project management skills, overall strategic direction and engagement with stakeholders and PABC.
- Consider local context and board member availability when deciding whether to establish an additional steering/planning group to oversee delivery.

Key resources

- See Annex 3 for the Durham governance structure
- See Annex 4 for Durham's programme manager role advertisement

Detailed scoping

Developing an implementation plan

The programme should be driven by a clear, widely-owned plan which sets out how it will be set up and delivered, for at least the duration of a defined pilot phase. This plan needs to set out the rationale for the changes proposed, an agreed assessment of the problem to be solved, the programme goal and how it might be reached, the offer and ask from different partners, and the added value for PABC.

The plan should also specify:

- how key elements of the programme will be delivered, such as care pathway design, recruitment and co-production
- timelines for delivery, including specific milestones
- budget and resources against key work programmes
- who is going to deliver key elements of the plan
- key performance and outcome indicators, with baseline measures and expectations on how change will be evidenced
- what the key risks are and how these will be mitigated.

This plan can be revised on a regular basis to reflect changes in policy or the local delivery context, but for the first period it must set out in detail who is expected to do what to deliver its key elements, with associated timelines and milestones.

Things to consider

- Use partnership events to map out the key elements of the programme plan, so that everyone is clear what is expected of them and different partners.
- Use theory of change models to map out potential outcome and performance measures, such as improvement to the wellbeing of PABC.

Top tips

- Build in opportunities at board meetings to review the plan, check progress against milestones, and review risks and mitigations

Key resources

- See Annexe 1: MLAP programme overarching Theory of Change

Embedding co-production

Co-production – a way of working whereby everybody works together on an equal basis to create a solution that works for them – has been at the heart of the MLAP approach. PABC need to be involved from the very start of any programme and given parity of esteem with all other stakeholders in the creation of any solutions.

See **Improving the cancer journey in Fife: Co-production** (video)

The Care Act (2014) guidance describes co-production as:

> *'When you as an individual influence the support and services you receive, or when groups of people get together to influence the way that services are designed, commissioned and delivered.'*

Co-production is **not** engagement or consultation. It should aim to involve people in:

- co-design, including planning services
- co-decision-making in the allocation of resources
- co-delivery of services, including the role of volunteers in providing the service
- co-evaluation of the service.

In several of the sites, PABC and carers have been involved in decisions throughout. It is recommended that any programme includes the following co-production practices:

- including PABC on programme boards as equal members
- setting up co-production forums or panels made up of PABC and carers, with clear terms of reference, meeting regularly with the programme team to provide valuable input
- training staff and volunteers in co-production principles and practice
- recruiting for specific co-production roles, such as user involvement facilitators or engagement officers
- ensuring that co-production includes the opportunity for input into the review and evaluation of the programme.

> *'We finally have a cancer voice on our project team and she has already made an impact by sharing her story openly and bringing a sense/reality check to our discussions.'*
>
> **Co-production panel member**

Learning from the areas indicates that successful co-production requires **commitment from the top** if it is to be consistent, ongoing and embedded as everyday practice. This should

include members of formal governance bodies, such as health and wellbeing boards in England and health and social care partnerships in Scotland, and elected members.

Additionally, co-production is most effective when supported by a **clear vision, strategy and delivery plan**. This helps to identify and agree with co-production participants the areas where co-production can have a real impact. If discussions simply focus on high-level aspirations, co-production will struggle to gain momentum. An effective approach can be to outline how co-production can be supported at three levels – at the strategic decision-making level (e.g. programme boards), at the operational level (how the programme is managed day to day) and at the individual service user level (how they are given a voice in how services are delivered).

Learning also indicates that **co-production can be time-consuming and requires dedicated resources** for building the project and for support. It is important that the costs of delivering co-production activities are included in budgets, and that the time to deliver these tasks is reflected in delivery plans. **Effective co-production requires excellent facilitation, research and communication skills**, which means it is important that the team includes individuals with these skills.

Co-production is a continuous process that will help to refine the programme and learn from those with lived experience. In several of the sites, opportunities for people living with cancer and carers to evaluate and review the programme were built in at the beginning. In Durham, for instance, the co-production group meet regularly to review how well the commissioned provider is delivering their MLAP-funded Joining the Dots cancer support service.

Case study: Co-production in Durham

Durham's MLAP Joining the Dots cancer support service has adopted an approach to the design and delivery of MLAP that is rooted in co-production. The site has drafted a co-production framework that outlines the vision and core principles of co-production for the MLAP. This framework has been agreed by all partners, and this facilitated their commitment and buy-in. The delivery of the programme is led by a co-production group, which reports to the programme board and oversees eight workstreams. The site has drafted clear terms of reference for this **co-production group**. This group also meets regularly to review how well the provider is delivering the Joining the Dots service. The site has also developed Joining the dots consultation video produced by PABC, to communicate the programme aims and how it will involve local people.

Additionally, the programme has recruited eight **co-production volunteers** (who are PABC) to be a key part of the project team. These volunteers have clearly outlined job/role descriptions and expectations, and have been provided with induction and training. They are represented on the programme board, the co-production group and workstream groups; others are tasked with undertaking carer and patient engagement.

More specifically, the co-production volunteers provided valuable input into the development of a suggested model of delivery. Durham then held an online public consultation on this model. The volunteers played a key role in designing the promotional materials for this consultation, including taking part in the production of a short video. The findings from the public consultation then fed into the development of a detailed service specification. The volunteers have also reviewed and supported decisions on the commissioning process and delivery provider selection.

As part of their patient and carer engagement, Durham has also held four Joining the Dots large-scale engagement events and conducted a **survey and one-to-one interviews** with people affected by cancer to better understand their experiences, journeys, gaps in services and support needs.

Finally, the site also employed the Macmillan Bus (a mobile information and support service), which has been a great success in helping the programme consult and engage in areas that had previously been inaccessible.

Also see Maintaining co-production.

Things to consider

- Develop (and agree among the board) a shared statement and vision of co-production, including the principles which will guide the process.
- Agree the definition of co-production so that all stakeholders have a shared understanding and can agree roles and responsibilities.
- Develop a co-production strategy, which clearly outlines where co-production can have an impact, how/when co-production partners will be involved and what the expected outcomes are of this involvement.
- Ensure project timescales and delivery plans include sufficient time for meaningful co-production activities.
- Set up co-production bodies such as user panels; employ dedicated co-production staff and people with lived experience on programme boards to act as champions and ensure co-production remains a priority area.
- Provide training for the co-production panel to ensure members have realistic expectations of their roles.
- Ensure your project team includes people with experience of co-production (e.g. facilitating co-production activities and running accessible meetings).
- Resource allocation must take account of the time and costs of co-production (e.g. venues, participant payments and the employment of dedicated co-production staff).

Top tips

- Ensure senior partners are committed to an approach grounded in co-production.
- Develop opportunities from the very beginning to involve people who have the greatest stake in services.
- Ensure co-production panels genuinely reflect the diverse communities of the local area including carers, disabled people and people from black and minority ethnic communities.
- Make sure that all information is accessible and in plain English (e.g. delivery plans, information sheets, web pages). Work with voluntary and community sector organisations and advocates to access seldom-heard communities and/or build on good practice already taking place locally.
- Make sure training and support is available for anyone involved in co-production and that this is ongoing.

Key resources

- See Annex 6 for Tower Hamlets' co-production communication flyer
- Co-production in Social Care; what is it and how do you do it (SCIE, 2015)
- Integrated Personal Commissioning – Co-production Guide (NHS England)
- Coalition for Collaborative Care – Co-production Model (Coalition for Collaborative Care, 2020)
- Scottish Co-production Network

Conducting key scoping activities

1. **Mapping existing assets in the community**
2. **Pathway modelling**
3. **Mapping the cancer landscape**

There are key scoping activities that need to be completed in Phase 1 of the programme to help inform the design of any new services or pathways and to make the best use of resources.

1. **Mapping existing assets in the community:** involves identifying any services, support or networks already available locally for PABC or that can be expanded to include cancer care (these need not be cancer-specific but simply responsive to the needs of PABC). This is not just a way to understand available resources that people may choose to access but is also a way to build networks and relationships across the system.
2. **Pathway modelling:** helps to understand the journeys of PABC and how and when different services and support networks are accessed and how they interact with each other. Learning from the MLAP sites has indicated that pathways can often be complex and unclear, particularly when services or support are going through transformative changes. Asset mapping and pathway modelling are therefore key to identifying areas of good practice, gaps, opportunities and synergies. This is essential in understanding where a new service/model/pathway can add most value in a joined-up way.

> *'Part of the process involved an asset-mapping process to look at the overall pathway for people with cancer and what support, networks, opportunities were available, and where the main gaps were. This… involved over 100 people from 89 different organisations.'*
>
> **Programme manager**

It is important for the sites to involve the voluntary sector in mapping pathways so that they can influence how these work, and explore the implications for demand on their services.

3. **Mapping the local cancer landscape:** accessing and reviewing datasets, research reports and publications, joint strategic needs assessments (JSNAs) and any other available information to build a rich picture of the profile of cancer in the local population. The sites felt that it was important to keep a close eye on national policy and delivery changes, which can have significant implications for local planning. Such mapping also helps establish a baseline for the profile of cancer, which will be useful for any evaluation, and in order to demonstrate to PABC what progress has been made by an MLAP.

The following specific datasets can provide you with a picture of local needs and issues for people living with cancer:

- Adult Social Care Outcomes Framework (in England)
- Public health cancer prevalence statistics
- Hospital Episode Statistics
- Scottish national datasets
- National Cancer Registry for Scotland
- National Cancer Patient Experience Survey
- Care Quality Commission (CQC) local authority profile
- GP survey results (Health and Social Care Survey in Scotland)
- Experiences of end-of-life survey
- Local research with communities including people living with cancer and carers.

In-depth engagement with PABC is needed at this stage to identify local people's concerns, needs, experiences and ambitions. Learning from the sites has indicated that such engagement can take place in a variety of ways, including but not limited to surveys, interviews, large-scale engagement events, online consultations, use of the Macmillan Bus to access harder-to-reach areas, as well as engagement with established panels and user groups (not always cancer-specific).

Learning from the sites has also indicated that the scoping activities described can require a lengthy and complex process. This is often because these activities cannot be completed in isolation and programme managers need time to engage, involve and build relationships with partners across the cancer pathway.

Finally, the scoping phase should include the **set-up of evaluation activities**. Thinking through at the beginning of the programme how you intend to measure and assess its impact is crucial to making a case in the future for its sustainability, as well as using this evaluation evidence to improve the programme. This may include commissioning an independent organisation to conduct the evaluation and working with partners to develop and agree a theory of change model to clearly outline the short- and longer-term outcomes expected, plus underpinning assumptions. Learning from sites has indicated that early engagement with evaluation activities and agreement of a theory of change model between partners can help avoid lengthy delays and help partners develop a vision together, enabling buy-in and ownership.

Things to consider

- Devise project timescales that allow sufficient time for robust asset and pathway mapping, which should be conducted as a priority, drawing on existing asset or service maps where necessary.
- Ensure that all partners, including the VCS, are involved in mapping pathways and assets.

- Allocate dedicated resources to asset and pathway mapping to ensure that programme managers have the support they need to complete these tasks, including support from data analysts.
- Ensure asset mapping is not a one-time activity but a continuous process to be built into the programme, whilst also considering resource implications.
- Allow sufficient time in project timescales for programme managers to focus on engaging and building relationships with key partners during the scoping phase.
- Engage with PABC using asset- and strength-based approaches.

Top tips

- Consider what local engagement work has already been completed on the needs and concerns of PABC to avoid duplication.
- Draw on other partners – such as community engagement teams – whose remit also includes engaging with PABC.
- Consider what asset mapping and pathway modelling tools already exist to help with these activities.

Key resources

- Asset Based Area (Think Local Act Personal, 2017)
- Strengths-based social work practice (Department of Health and Social Care)
- Asset based places – A model for development (SCIE, 2017)

Building productive relationships and partnerships

Any programme requires a wide range of services and practitioners to work together. This is likely to include the organisations and practitioners listed below.

Key organisations

- clinical commissioning groups (CCGs) in England
- NHS Boards (Scotland)
- local Health Boards (Wales)
- Health and Social Care Trusts (NI)
- Macmillan Cancer Support
- local voluntary and community sector organisations, including cancer-specific and carer-focused bodies
- NHS trusts
- GP practices
- care homes
- leisure services
- faith organisations

- hospices
- housing
- PABC

Key practitioners

- GPs/practice nurses/advanced nurse practitioners
- allied health professionals (AHPs)
- social workers
- home care workers
- housing officers
- care coordinators/link workers/care navigators
- cancer nurse specialists
- district nurses
- community pharmacists
- hospital cancer clinicians
- palliative care specialists.

The involvement of so many partners means that coordination, cooperation, communication and agreement are essential to establish productive relationships that move the programme forward. Local authorities are well placed to pull together and secure MLAP involvement from a diverse range of partners, across health, social care, housing and other sectors because of their democratic mandate and their role as leaders of their local communities.

Learning from the sites has indicated that partnership working often requires disparate professionals and teams to work together. It is therefore likely that disagreements and issues will arise that need to be addressed. At the strategic level, partner organisations can understandably have conflicting interests and priorities both between each other and with Macmillan for example, with respect to defining the scope of the programme, its outcomes and evaluation, and its applicability to other LTCs.

Additionally, at the **site delivery level**, MLAPs seek to coordinate care and support around individuals, and therefore require effective multidisciplinary and cross-agency working in order to avoid delays to the programme set-up and the ongoing delivery of any commissioned service/changes to pathways. Effective joint working between practitioners is likely to be needed throughout the time a person is supported by the programme to produce an HNA, to develop a personalised care plan, to bring together the right package of care for the person or to review whether the person's goals are being met. However, agencies often work to different timescales and are faced by different competing pressures (as well as bureaucratic processes) that can make efficient joint working difficult. Additionally, providers and services often tend to work in 'silos'.

Teams working locally to support PABC need:

- clear criteria for referrals or processes
- an identified manager and/or leader who oversees and facilitates the work of the whole team
- a single process to access the workers in the team, with joint meetings to share insights and concerns
- electronic records of all contacts, assessments and interventions by team members with an individual and their family
- a 'key worker' system through which care for those with complex support packages is coordinated by a named team member, who will help people identify the support they need and use a personal budget (if they have one), and signpost people to services
- a clear understanding of each other's roles and responsibilities concerning the individual and how to contact one another when required
- trust and relationships between professionals, community support and individuals (key to building a seamless experience of care and support).

Case study: Encouraging service delivery in Dundee

Dundee was the first MLAP site to launch its service, Improving the Cancer Journey (ICJ). Scoping and development started in July 2016 and, following a brief test period, the Dundee ICJ had a successful public launch in November 2017. In its first year of operation, the team completed over 250 HNAs.

A broadly equal number of men and women use the service with most being over 55. Initially, most service users were 75 and over, but uptake amongst younger age groups has increased as time has gone on. Sixty-three per cent of the people the team meet come from the two most deprived datazones (Scottish Multiple Index of Deprivation areas 1 and 2). Service users have raised over 3,000 concerns (an average of nine per person) so far, and the team has taken just under 3,500 actions on their behalf.

The ICJ team and its co-production panel, Cancer Voices, identified a gap in the provision of low-level emotional support for PABC. Over 2018, the group worked with Volunteer Dundee to develop a volunteer-led peer support model to help address the gap and some of the issues that were being raised by service users. The team and Cancer Voices worked with a range of organisations across the city to develop a programme of health and wellbeing events for people affected by cancer. The first event took place in October 2018.

This promising practice is underpinned by the drive of the Chief Executive of the Council and the buy-in of senior leaders on the project board. A strong history of partnership working in Dundee has helped the service to move forward. The previous experience of the Tayside Transforming Care After Treatment (TCAT), Welfare Rights and Move More programmes, as well as the adaptability of the Glasgow ICJ, has also helped facilitate the design and delivery of the service.

Things to consider

- Develop a clear map of all the different internal and external stakeholders who need to be involved and agree this with the programme board.

- Develop a narrative for the programme with a wide range of stakeholders, which clearly sets its ambitions, intended outcomes and agreed ways of working, to facilitate commitment and ownership by all involved.
- Work with partners (including the voluntary and community sectors and PABC) to develop delivery plans that clearly outline how and when partner organisations will work together (e.g., referrals, completion of HNAs), with clear expectations about roles, responsibilities and outcomes.
- Identify and agree, where possible, dedicated points of contact within agencies, to ensure communication is efficient.
- Establish opportunities for joint training and cross-agency team meetings, to build understanding and a shared culture.
- Have a clear plan for communication with stakeholders and people with cancer and their carers, and a relentless focus on communicating the vision.

Top tips

- Senior level partners should model effective partnership working (e.g., by doing joint presentations at events).
- Senior level partners should be visible throughout the change process, attending and facilitating key meetings and consultation events.
- Encourage mutual respect and sensitivity to establish productive working relationships.
- Encourage face-to-face meetings and discussions in the early months of the programme.

Key resources

- Delivering integrated care: the role of the multidisciplinary team (SCIE, 2019)
- How to lead and manage better care (SCIE, 2019)
- Leadership in integrated care systems (ICSs) (SCIE and NHS Leadership Academy, 2018)
- System leadership (The King's Fund)
- See Annex 7 for list of key prompt questions Macmillan has developed

Implementation and piloting

Draw on local context

The implementation of any programme and the design and commissioning of any new service/model/pathway depends very much on the local context and existing infrastructure and provision for cancer care.

For example, learning has indicated that the ease of implementation of the programme can depend very much on **existing relationships and partnerships**. This can include:

- good relationships between the local authority and health services
- the existence of integrated health and wellbeing partnerships

- strong engagement with clinicians
- established cancer patient involvement bodies.

More broadly, it can also include an existing commitment to a personalised approach, and an understanding and drive to invest in community capacity and the voluntary and community sector.

Learning also indicates that implementation of an MLAP is shaped and facilitated by local areas' previous delivery of **services and programmes** with similar core principles and functions. This can include having access to:

- established approaches for asset mapping and pathway modelling
- in-depth engagement work with PABC, providing a rich picture of the needs of local people
- co-production infrastructure, including working groups, panels, strategies and delivery plans
- a tried-and-tested model for delivery
- existing relationships with clinicians and other medical staff
- adaptable approaches to HNAs.

Taken together, this local experience and context can provide localities with a strong foundation from which to design and commission a service/or improvement for delivery. For example, the Scottish sites have drawn on their experience with the Improving the Cancer Journey and implemented a similar delivery model.

On the other hand, the scoping activities from other sites have indicated that the **design of a new service may not be the best use of resources**, particularly where localities are undergoing transformative change and/or have a varied and complex cancer provision landscape. Instead, service review and improvement to build on existing infrastructure has been identified as a priority in these types of localities. At such sites, where a new service is not identified as appropriate, the programme can develop a plan for how existing services can work better together.

Things to consider

- Consider, build and apply learning from any previous/existing local programmes with similar principles and functions.
- Analyse existing models that have successfully been implemented to help inform what works well and which aspects may be transferable to the local context.
- Identify and build on existing relationships and partnerships with a commitment to personalised care towards cancer and support.

Top tips

- Scope activities as a priority where local areas have little similar experience or a complex cancer landscape.

- Consider whether a new service is needed or most appropriate for the local context, or whether a focus on pathways and refining existing provision is more appropriate.
- Make expected service delivery models and timescales flexible and adaptable as local areas have varying context.
- Ensure there is a senior level champion and the political to make sure the programme is considered a priority in an already crowded policy context.
- Agree how to communicate about and market the scheme, to raise awareness and clarify who it is for and how to access it. Consider existing communication channels/services reaching PABC as part of this planning, as well as resourcing required.

Key resources

- See Annex 6 for ICJ client pathway
- Transforming Care After Treatment (TCAT) in Scotland.

Sustaining delivery

Designing services that will be sustainable over time

Each of the pilot sites is unique, with different histories of joint working, populations and approaches to supporting people. The MLAP programme was designed in a way which sought to avoid imposing too many restrictions on how the partnerships went about designing local care services for PABC.

Whilst each site ended up with different delivery models, with some sites more focused on home-based HNAs rather than conducting them in community care settings for instance, a common feature was the creation of **facilitator or link worker roles** based in delivery teams. It is important to think carefully about how this group of workers is recruited, trained and developed.

In developing specifications for recruiting link workers, it is worth referring to the growing body of resources aimed at supporting the development of link workers, or care coordinators, especially the National Association of Link Workers.

Key skills this group of workers needs to have include:

- giving people time to tell their stories and focus on ‘what matters to me’
- building trust with the person, providing non-judgemental support, respecting diversity and lifestyle choices
- seeking regular feedback about the quality of service and impact of social prescribing on referral agencies
- helping people identify the wider issues that impact on their health and wellbeing, such as debt, poor housing, being unemployed, loneliness and caring responsibilities
- working with the person, their families and carers to consider how they can all be supported by the service

- helping people maintain or regain independence through living skills, adaptations, enablement approaches and simple safeguards
- working with individuals to co-produce HNAs and simple personalised support plans – based on the person's priorities, interests, values and motivation
- being proactive in developing strong links with all local agencies to encourage referrals, recognising what they need to be confident in the service to make appropriate referrals
- forging strong links with local VCS organisations, community and neighbourhood level groups, utilising their networks and building on what's already available to create a map or menu of community groups and assets.

Developing the team

All four sites grasped the importance of investing in and developing their teams. Some of the key roles that underpin the service, such as the facilitators/link workers lack a clear career pathway so it is important to invest in their development. For example, Dundee and Fife funded their link workers to complete Macmillan training and undertake shadowing of Glasgow Improving Cancer Journey workers.

The facilitators/link workers also undertook local authority training modules, spent time with nursing teams to understand the services currently being delivered, and received support from the Macmillan Nurse Consultant (Cancer), who is a trained coach, clinical supervisor and mentor. The Macmillan Nurse Consultant provided formal clinical supervision in the form of peer learning sessions for facilitators as well as formal evaluations. The workers received ongoing support from the programme manager and attended action learning sets. In Fife, in addition to the action learning sets, speakers presented at team meetings, for example those running local support organisations.

Aligning to new and emerging policies and programmes

The integrated care agenda in both nations has not stood still, and it has been critical for sites to scan for up-and-coming policy changes and rapidly adjust their programmes when needed to align with new initiatives, such as the creation of primary care networks (PCNs) and roll-out of social prescribing in England.

As opportunities arose, sites actively tried to position themselves to take advantage of them. For example, the ICJ in Fife was included in the Health and Social Care Partnership's Strategic Plan for 2019–2022. In the context of a tight fiscal climate and associated restructuring of services, it was important for the ICJ service to be given this strategic commitment. The plan included the goal of establishing an opt-out model, whereby every person in Fife who received a cancer diagnosis would be offered the service by NHS Fife, trying to ensure 100 per cent coverage where even the ISD letter does not reach every person diagnosed with cancer (due to data issues).

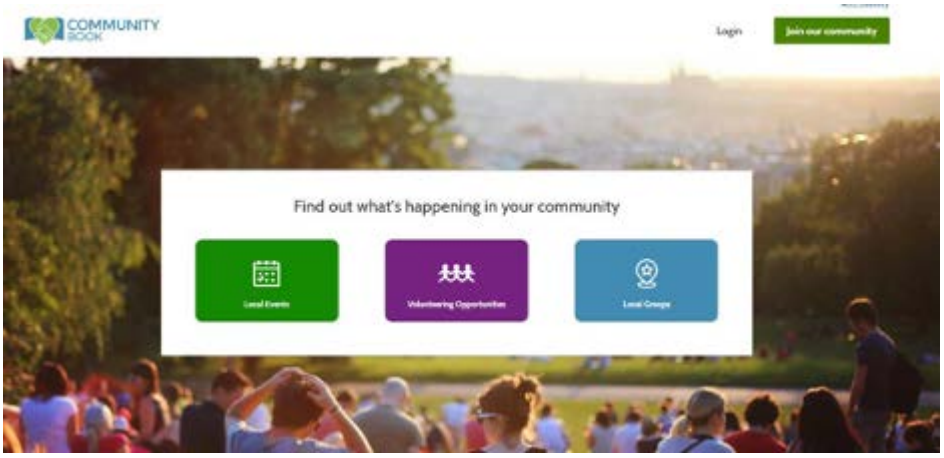
In England, the development of PCNs offers a fresh opportunity to engage local primary care, public health and social care partners in supporting a local partnership devoted to supporting PABC. PCNs receive funding for social prescribing, so there is a need to collaborate to avoid duplication of effort.

Keeping up to date with changing community assets

The assets and social networks which exist in communities are always evolving. All sites have commented on **how challenging it is to maintain up-to-date knowledge of community assets**. An asset map is a live resource, that needs to be regularly updated.

In this context, it is important to see asset mapping as part of people's day job – something that workers are constantly looking to explore and understand through their interactions with PABC, carers and wider communities.

In some parts of the country, local authorities and their partners have invested in good online directories which both workers and people who use services can access. ALISS (A Local Information Service for Scotland), which provides information on health and wellbeing and VCS services for people living with long-term conditions, disabled people and unpaid carers is one such example.



Durham, for instance, has managed to build a really accessible and up-to-date directory of local services called Locate, which signposts people to a very wide range of services including money advice, information and advice, getting out and about and care and support services.

Good strengths- or asset-based practice involves asking questions about people's skills, networks and local resources, and then feeding this back into discussions with colleagues about local assets. Those implementing the MLAP approach should consider providing strengths-based practice training to workers, so that they are equipped with the skills of regularly discussing and gathering knowledge about local assets.

Maintaining co-production

Maintaining good co-production, beyond the initial set-up of a new programme, can often present considerable challenges. All of the sites found effective ways to maintain co-production as part of business as usual through a range of activities including co-production panels and regular focus groups, surveys and events with PABC.

A common message we heard from the sites is the need to identify where co-production can have a genuine impact, so that what people get involved in is meaningful, engaging and makes a difference.

Key activities in which the sites got volunteers involved included:

Design support

Co-production volunteers helped to identify and define the particular issues facing PABC locally and provided input to potential solutions. This was exemplified by Durham, where a new group of co-production volunteers were found and multiple meetings held for them to go through a process of eliciting and identifying local issues then brainstorming potential solutions.

Delivery support

Co-production volunteers delivered activities to support the programme, such as being involved in link worker and programme manager recruitment, delivering promotional events to raise the profile of the service, redesigning the social media offer, and helping to support link workers in the delivery of HNAs. This highlights the range of skills and interests needed amongst panel members – and those supporting co-production from the programme team.

Advisory

Co-production offered the programme team insights or advice on particular topics. For example, co-production groups reviewed MLAP materials such as communication materials and evaluation surveys, and set up a peer review steering group to re-purpose their role as the MLAP shifted from design into delivery. This latter point highlights the flexibility needed in how the panels function and operate, to reflect MLAP evolution locally. This requires careful negotiation with panel members, to ensure the remit continues to suit both panel members' needs and partnership requirements.

Other actions that helped embed co-production include:

- ensuring that regular co-production panel meetings are planned well in advance into diaries
- identifying and training staff based in the service to become co-production champions, who have the commitment and skills to promote co-production within their part of the programme
- co-producing a clear and agreed workplan for co-production volunteers which engages them in meaningful and purposive activities
- ensuring that there is ongoing support for co-production available within the delivery team. For example, one site had a role dedicated to co-production within their programme team and one had a team member with co-production expertise.

Managing performance

The delivery plan agreed at the start of the programme should set out clear expectations on performance and outcomes, and include key performance indicators.

There is always a danger that delivery plans are allowed to drift without regular oversight and action to resolve issues and prevent delays.

Key to this is working effectively with people who have skills in accessing and analysing performance data, so that you can track the impact of the programme

Pilot sites emphasised that it was important to take the implementation plan to the partnership board regularly, to review progress and assess emerging risks.

Things to consider

- Spend time scoping out the local demographics and cancer data, mapping local assets and pathways, co-production and liaising with a wide range of stakeholders to fully understand the context and how it would affect (and be affected by) an MLAP.
- Build expert capability into your delivery team to support ongoing co-production.
- Provide training to the delivery team in asset-based and strengths-based approaches, particularly focusing on how they build and maintain a good understanding of local assets.

Top tips

- Ensure that the partnership board formally reviews performance in relation to the implementation plans at least quarterly each year.
- Ensure that team meetings and programme board meetings regularly involve horizon scanning and policy discussions so that there is a high level of awareness of emerging policy agendas.
- Involve colleagues from primary care networks (in England) and integrated health and care partnerships (in Scotland), in developing job descriptions for link workers.

Key resources

- Social Prescribing Summary Guide (NHS England and Improvement, June 2020)
- Primary care Networks – one year on (NHS Confederation, 2020)
- Evidence for strengths and asset-based outcomes, Quick guide for social workers (SCIE/NICE, 2019)

Contact

For more information, contact Macmillan Cancer Support at **EvaluationClinic@macmillan.org.uk** .

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About this report

This guide focus on implementing system change in cancer care by drawing on the experience of the Macmillan Local Authority Partnership (MLAP) programme. The guide supprts leaders, commissioners and practitioners from health, social care, housing, and voluntary and community sector organisations to implement a person-centred, integrated approach to providing care and support to people affected by cancer (PABC). It can also be used to support people affected by other long-term conditions (LTCs).

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