EVALUATION OF MANVAN

Final Report

for Tenovus Cancer Care, Prostate Cancer UK and Movember

Mark Llewellyn and Jennifer Hilgart
Welsh Institute for Health and Social Care · University of South Wales

April 2016

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SUMMARY

APPROACH

The Welsh Institute for Health and Social Care, University of South Wales, was commissioned by ManVan to undertake an independent evaluation. After undertaking a literature review, a mixed methods approach was used to gather perspectives from ManVan clients, men who are engaged with support groups, clinicians and ManVan staff and managers. The evaluators also visited the Van whilst it was providing support to people. It should be noted that there are a number of limitations to this study, most notably the size of the evaluation budget which equated 18 days for the study team.

FINDINGS

Among others, the following represent the key findings from the study:

- There is overall satisfaction that the Van has provided a ‘man-friendly’ service;
- The Van provides an opportunity to speak in a way or a depth that is not possible during clinics;
- Staff on the Van are a reassuring and expert resource for both NHS staff and beneficiaries; and
- One of the key strengths of the ManVan is offering a holistic approach, and in unifying the offering of nurse advisors, counsellor and cancer support adviser.

DISCUSSION

In discussing these findings, the evaluators considered the role and remit of the ManVan and whether, despite the limitations placed on what can be delivered by the contract, the Van should think about expanding the range of services it offers. Whilst the staff mix as described above is a positive, the way in which the service has been delivered has not allowed for that impact to be optimised. This has meant that in a number of health board areas in Wales, the Van has ‘under-delivered’, especially when compared to others. Accordingly the unit cost for a ManVan appointment varies significantly across Wales – from £106.39 to £586.48, where the mean is £205.85. Further, there is a mis-match between where the ManVan is spending its budget, and where it receives the greatest number of appointments, questioning whether the Van provides value for money.

CONCLUSION

Overall, the ManVan has delivered a professional and valued service to a number of men in Wales over the last two years. The service values of being approachable, empathetic and supportive have ensured that it has, in certain parts of Wales, become well-respected. A key challenge is that the ManVan has not been able to achieve this success universally and as such the impact and cost of the service has varied across Wales. There are a number of options for the future, and the study has come to the following five conclusions:

One The ManVan is currently working under-capacity in more than half of Wales’ Health Boards.

Two The service model is not consistent with how some services need to be delivered.

Three The ManVan ‘mode’ of working is inefficient, as it has not proved possible to maintain a constant throughput of people who want to access support face-to-face on the Van, like for the nursing appointments.

Four The significant overheads of running and maintaining the vehicle mean that it is a costly way of providing such support.

Five As a pilot and ‘proof of concept’ the ManVan has much to recommend it – it has worked for many people. It is apparent that these people could have accessed similar forms of support in other ways.

1. INTRODUCTION

PROJECT SYNOPSIS

Prostate Cancer UK and Tenovus Cancer Care commissioned the Welsh Institute of Health and Social Care (WIHSC) to undertake an evaluation of the ManVan mobile support service. The ManVan is a new initiative by Prostate Cancer UK and Tenovus Cancer Care. It provides mobile cancer support to men living with, and affected by prostate, testicular and penile cancer. Specifically it aims to:

- promote a meaningful quality of life for men affected by prostate, testicular, and penile cancer through the provision of a suite of survivorship services;
- improve knowledge and understanding of the consequences/side effects of treatments;
- manage better the expectations men have after their diagnosis and treatment;
- increase access to counselling and emotional support services to improve both physical and mental well-being; and
- enhance the quality of life of men surviving prostate, testicular and penile cancer and their families, carers, and friends.

The ManVan commenced service delivery on 1st April 2014 and is the United Kingdom's first dedicated mobile support service for men affected by prostate, testicular, and penile cancer. It is fully funded by the Movember Foundation.

The ManVan team consists of a full-time counsellor providing one-to-one, group and couples' counselling, a Cancer Support Advisor (CSA) to help with benefits and welfare advice, and two part-time nurses. This service is the first time that nursing care, counselling for individuals and couples, group support and welfare rights advice, has been delivered directly to men living with prostate, testicular and penile cancer in communities across Wales. During its first year, the ManVan travelled extensively across Wales, seeking to reach patients living in deprived or hard to reach areas, visiting 94 different locations, across seven Local Health Board areas.

METHOD

The evaluation comprised of several strands. Firstly, the WIHSC team conducted a scoping search of the literature to identify any evidence relevant to the ManVan evaluation, such as models of support services for men with cancer and other evaluations of outreach/mobile services for cancer patients. Key words were used to search the published literature for relevant studies. In this early stage of the evaluation, a focus group was held with men who were all involved with support groups, who provided a very useful set of perspectives on the role of the Van.

Ten semi-structured interviews were undertaken with urology clinical staff including clinical nurse specialists and consultants from 4 health boards across Wales: Cwm Taf, Cardiff and Vale, Betsi Cadwaladr, and Hywel Dda. The contact details of healthcare professionals were provided by Tenovus staff. All clinicians were informed about the aims of the evaluation and it was stressed that participation in the evaluation was entirely voluntary. A majority of these interviews were conducted over the telephone and aimed to explore clinical staff knowledge and opinions about the ManVan, the service model, and how it impacted on their patients. Interviewees were also asked about the features and services of the ManVan which they value the most, if the services offered compliment their clinical work or provide support that the NHS can't provide in any other way. The interviews lasted between 15 and 30 minutes.

Interviews were also conducted with two ManVan clients and their partners. Again, contact details were gained from the ManVan team who asked these clients if they would be happy to be contacted by WIHSC for the purposes of the evaluation. These client interviews were both conducted over the phone. All interview recordings were transcribed and then organised into themes by looking for patterns within the data.

The WIHSC team also visited the ManVan 'in action' on site at Velindre Cancer Centre, Royal Glamorgan Hospital and Prince Philip Hospital. Two of these visits were unannounced visits and coincided with visits to the urology clinics at these sites. Discussions were had with urology clinical staff and ManVan staff to explore the utilisation of the van and the relationships between ManVan and clinical staff.

Further, WIHSC conducted seven interviews with ManVan staff and managers at Tenovus Cancer Care head office in Cardiff. These interviews aimed to explore their views of the ManVan, including the perceived impact of the Van on patients and healthcare professionals, the strengths and limitations of the service model provided, and their thoughts about the future of the service for men with prostate, penile and testicular cancer across Wales. WIHSC requested ManVan activity and cost data from Tenovus and used the existing data presented in the quarterly and annual reports for the purposes of the evaluation.

Limitations

Several limitations of the evaluation should be noted at this stage. Firstly the client interviewees were selected by ManVan staff which may have introduced some bias as they may be likely to select clients who had multiple interactions with the ManVan and have built good relationships with the ManVan staff. Also only two clients were interviewed as the main aim of the evaluation was to explore the wider impact and effectiveness of the van on clinical services and healthcare professionals rather than on individual cancer patients.

There were also limitations present in the data provided by Tenovus, for example there was no information about which hospital site patients were seen from, how patients heard of the service, date of the first visit to the ManVan, and the length of time of appointments. Also for the activity data presented, the CSA does not record a telephone call as an appointment, and therefore only face to face numbers are shown. Further, we acknowledge that this data does not represent every person that has had contact with the staff and services on the ManVan, as client contacts were not recorded in full when the ManVan first started. The data does not capture the more informal clinical conversations or visitors to the van who may have benefitted from the information they received. Also many visitors to the Van have queries about cancers other than prostate, penile and testicular, which the ManVan staff respond to, but this is not captured in the data collected.

The literature review was also limited by the lack of UK studies, so caution is warranted when generalising evidence from the USA and Australia to the Welsh context.

Finally, it is worth stating that the evaluation was completed within a budget of time equal to 18 days to complete all of the phases of the project. As such, whilst the evaluation team sought to complete the work in as time efficient a manner as possible, there are obvious constraints given this allocation.

LITERATURE

The literature review did not yield any papers that specifically compared different models of service delivery e.g. providing cancer information and support in a hospital setting versus on a mobile unit/in the community. There was also no literature which looked at the provision of welfare benefits, counselling and nursing advice in one setting. The published evidence relating to this evaluation is summarised here and is also cited within the discussion section of the report.

One systematic review concluded that many men with prostate cancer and their partners have information needs that are not met by healthcare professionals.[1] The greatest unmet need in men with prostate cancer may be for information, especially knowledge of side effects of the illness and its treatment, and on issues related to recurrence.[2] However men's needs will depend on stage of the cancer, the treatment they receive, and levels of existing support.[3] Services have attempted to meet the information, psychosocial and financial needs of patients with cancer, and studies have attempted to explore information-seeking behaviour[1] and barriers to the use of cancer support and information services.[4] One study found that the most commonly reported patient barriers to using cancer support services were already having adequate support, lack of awareness of the service, and lack of healthcare provider referral.[4] These findings point to the importance of provider referrals to, and endorsement of, cancer support services. Further, they suggest that additional outreach efforts are needed to increase patient awareness of existing services and to educate patients as to the benefits of cancer support services.

The importance of clinician referral to cancer support services provided by voluntary organisations was further highlighted by a recent study in Finland.[5] This study suggested that integration of a counselling service within the cancer health service was more likely when the counselling service resulted in the reduction in the workload of the clinic staff. For example, clients stated that they sometimes contacted the counselling service rather than the hospital staff. Integration was also improved when the hospital staff made the counselling service visible, encouraged patients to contact the service and showed patients that they trusted the expertise of the counselling nurses.

The importance of the relationship between non-profit cancer services and health and social care is further demonstrated in a report of a welfare rights advice service for people affected by cancer, which was developed by Durham County Council and MacMillan Cancer Support.[6] This service commenced after a two and half year development phase when '*considerable effort was invested in furthering links between welfare rights advice services and the existing network of services providing support to people with cancer*'. Prior to the service starting, the senior manager liaised closely with a wide range of health professionals in order to publicise the service, but also to obtain views on the optimal methods of referral. Healthcare staff involved in managing the benefit needs of people with cancer reported that completing the various forms was time-consuming and they were not clear exactly which benefits clients might be entitled to. The result being that patients were referred in an ad hoc way to other services such as the Citizens Advice Bureau or Age Concern. The welfare rights advisers worked in different types of locations (hospitals, Macmillan cancer information centres, and general practice surgeries) depending on existing local services. The advisors also provided the service via home visits, email and telephone. Through the process of offering advice and assistance to claim benefits, the advisers also referred to other statutory and voluntary services if required. The advisors undertook outreach work with a range of professionals including social services and the voluntary sector to raise awareness of the service and increase referral rates. In one year (2009-

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[1] Echlin KN, Rees CE (2002) Information needs and information-seeking behaviours of men with prostate cancer and their partners: a review of the literature. Cancer Nursing; 25(1):35-41.

[2] Boberg EW, Gustafson DH, Hawkins RP, et al. (2003). Assessing the unmet information, support and care delivery needs of men with prostate cancer. Patient Educ. Couns., 49:223–242

[3] Steginga, S.K., Occhipinti, S., Dunn, J., Gardiner, R.A., Heathcote, P. and Yaxley, J. (2001), The supportive care needs of men with prostate cancer. Psycho-Oncology, 10: 66–75.

[4] Eakin EG, Strycker LA. Awareness and barriers to use of cancer support and information resources by HMO patients with breast, prostate or colon cancer: patient and provider perspectives. Psycho-Oncology 2001;10:103–104.

[5] Yli-Uotila T, Kaunonen M, Pylkkänen L, Suominen T. (2016). The need for social support provided by the non-profit cancer societies throughout different phases in the cancer trajectory and its integration into public healthcare. Eur J Oncol Nurs;21:97-104

[6] Noble E, Moffatt S, White M. The impact of a dedicated welfare rights advice service for people affected by cancer. www.nepho.org.uk/

2010), the three welfare rights advisors conducted 1231 consultations with 1174 individuals,[7] with 40% of referrals coming from health professionals in either primary or secondary care.

A survey of cancer patients in Northern Ireland revealed that people affected by cancer wanted a cancer information and support centre (CISC) to be a 'medical' and 'white coat' free zone, a place where individuals could 'relax', 'have a cup of coffee', 'recharge batteries', 'escape' and, 'in their own time', receive help to understand their diagnosis and treatment options and, be signposted to other support services and assistance.[8] Men were less likely to regard formal counselling sessions as important, and appeared to prefer to speak to other men who had shared a similar experience. 62% of patients (and 81% of carers) thought it was important for the CISC to provide programmes that would enable carers to talk more openly and help understand how cancer patients might 'feel'. A total of 86% of respondents thought it important to provide financial advice, with 66% wanting the CISC to help patients complete the 'complex' paperwork. Approximately 75% of patients (and 91% of carers) thought it would be important for the CISC to provide the opportunity to talk to a professionally trained member of staff who could provide context to their diagnosis and treatment plan.

One UK study reported that if the introduction of outreach, primary care and community-based services was supported by a core of hospital-based information and support, these services could then be more effective than they might be as 'stand alone' initiatives.[9] There was also an awareness of the need to be sensitive to professional boundaries if good networking relationships were to be developed and maintained. For example, many cancer support service staff found it necessary to disabuse Clinical Nurse Specialists of the notion that they were trying to take over their roles. Clear lines of communication were recognised as being essential to productive working relationships. Examples of the use of volunteers in CISC included giving volunteers responsibility for maintaining information, or arranging for them to have links with a particular ward and visit on a regular basis. This study also identified certain 'success factors' which could make a significant contribution to the development of responsive, patient-centred and sustainable cancer information and support services:

- Planning a service based on an assessment of need (including an estimation of the likely usage of the proposed service by people affected by cancer) and having adequate and sustainable capacity (staffing and resources) to deliver an inclusive, holistic service;
- Creating a non-clinical environment, where people affected by cancer can be supported by a team of paid workers, volunteers, and clinical staff as needed;
- Creating a service that optimizes the physical space available and is not bound by it – developing in-reach as well as outreach approaches to a service that is networked into its local communities;
- Creating a service that is integrated into and supported by its host, and still has an external, user-centred focus – building its capacity through other community agencies to extend reach; and
- Creating a service that builds on existing initiatives and skills available within the host organization, and optimizes the contribution of external agencies and individuals.

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[7] Moffatt S, Noble E, White M. (2012). Addressing the financial consequences of cancer: Qualitative evaluation of a welfare rights advice service. PLOS ONE 7(8): 1-10.

[8] Manning, D.L. and Dickens, C. (2007), Cancer Information and Support Centres: fixing parts cancer drugs cannot reach. European Journal of Cancer Care, 16: 33–38.

[9] Smith, C., Dickens, C. and Edwards, S. (2005), Provision of information for cancer patients: an appraisal and review. European Journal of Cancer Care, 14: 282–288.

One Australian evaluation of a hospital-based 'drop-in' CISC which was located in the outpatient clinic area and staffed by a cancer support nurse and trained volunteers.[10] The volunteer contacts were often in the outpatient waiting area offering support to those waiting for appointments. Contact with the cancer support nurse was primarily face-to-face or over the telephone.

The main reasons for contacting the CISC included requiring cancer specific information and for cancer treatment-related information. Almost half of CISC clients had accessed the service between 2 and 6 times. Contact with the nurse and the volunteers resulted in internal or community based referrals for many patients. Living too far from the hospital was a key reason for those clients who did not want any additional support. For this reason, mobile or outreach services which can bring cancer information and support closer to where people live maybe valued.[11] In this study of a UK mobile cancer information unit which offered drop in cancer information and support service in the community, with an average of 53 visitors per day, of whom 16 were recorded contacts. 30% (n=3937) of all visitors had a recorded contact with a member of staff. 40% of contacts were male. 95% of contacts visited as they were just passing and most did not have cancer themselves. Of those who had cancer the second most common cancer type (after breast) was prostate cancer. 23% of enquiries related to prevention (screening, genetic testing, exercise, diet, and stopping smoking). 15% of enquiries were about living with cancer (financial benefits, emotional support, treatment and follow-up). 40% were signposted to other sources of information or support, 71% received written literature.

Bringing cancer services into the community has also been achieved by having treatment for cancer outside of the hospital setting. This has been developed in Wales[12] and the South West of England.[13] The benefits of receiving treatment such as chemotherapy closer to home has several benefits for clients including reduced travel time and costs such as fuel and car-parking, and reduced waiting time compared to the clinic appointments. The use of remote services using telephone support, email and the internet have also been explored. One study from the Netherlands found travel distance influenced interest and participation in prostate cancer support groups.[14] The literature review also suggested that the use of telephone support may be particularly welcomed by men with cancer. A study of men with cancer living in rural Australia found that highest rates of participation in a support service were for cancer organisations that offer support via telephone or the internet.[15] This type of support offers the opportunity for easy and anonymous access, where factors like geographic isolation, physical limitations and discomfort with face-to-face approaches make seeking formal support difficult. In a study that investigated the use of telephone-based decision support for men newly diagnosed with prostate cancer, a high level of satisfaction with the intervention was reported, as were the benefits of using a service that was accessible and anonymous.[16] Seeking support anonymously avoids any stigma attached to seeking help for an emotional problem, concern over

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[10] Kinane, NA. (2012). Evaluation of a hospital-based cancer information and support centre. Supportive Care in Cancer, 20: 287-300.

[11] Foster C., Scott I. & Addington-Hall J. (2010) Who visits mobile UK services providing cancer information and support in the community? European Journal of Cancer Care 19, 221–226.

[12] Iredale, R., Hilgart, J. and Hayward, J. (2011), Patient perceptions of a mobile cancer support unit in South Wales. European Journal of Cancer Care, 20: 555–560.

[13] Mitchell T. (2013) Patients' experiences of receiving chemotherapy in outpatient clinic and/or onboard a unique nurse-led mobile chemotherapy unit: a qualitative study. European Journal of Cancer Care, 22(4):430-439

[14] Voerman B, Visser A, Fischer M, Garssen B, van Andel G, Bensing J. Determinants of participation in social support groups for prostate cancer patients. Psycho-Oncology 2007; 16: 1092–1099.

[15] Corboy D, McLaren S, McDonald J. Predictors of support service use by rural and regional men with cancer. Aust. J. Rural Health 2011; 19, 185–190

[16] Steginga S, Ferguson M, Clutton S, Gardiner RA, Nicol D. Early decision and psychosocial support intervention for men with localised prostate cancer: an integrated approach. Supportive Care in Cancer 2008; 16: 821–829.

which has been found to be higher among rural residents than among urban residents.[17]

In conclusion, cancer information and support services, whether placed in a hospital or a community setting, have an important role to play in cancer patients' quality of life. They can fill the gaps in patients unmet or changing information needs about their cancer diagnosis and treatment. Information given by healthcare professionals can often be overwhelming and patients place importance on having the opportunity to speak to a knowledgeable person to reinforce the information that has been given. The voluntary sector can also deliver services that healthcare professionals are unable to provide given the time constraints and lack of expertise, these include welfare benefits advice and sufficient emotional support or counselling. The literature reviewed here identified the need to build services based on an assessment of need and consideration of existing local services. Building awareness of the service as well as strong relationships with healthcare staff, social services and voluntary sector was also an important determinant of a successful service.

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[17] Hoyt DR, Conger RD, Valde JG. Psychological distress and help seeking in rural America. American Journal of Community Psychology 1997; 25: 449–470.

2. FINDINGS

ACTIVITY DATA

The following data was received from Tenovus and represents 337 people with a full set of information up until February 2016 (those who have information on both Neo and SPSS databases). 5 clients in the database did not have data for any appointments. Client demographic information is provided in Table 2.1. Most patients (70%) were married and a large majority had prostate cancer (83%). Nearly half the clients were from two of the seven health boards: Betsi Cadwaladr and Hywel Dda.

Table 2.1 · Client demographics (n=337)

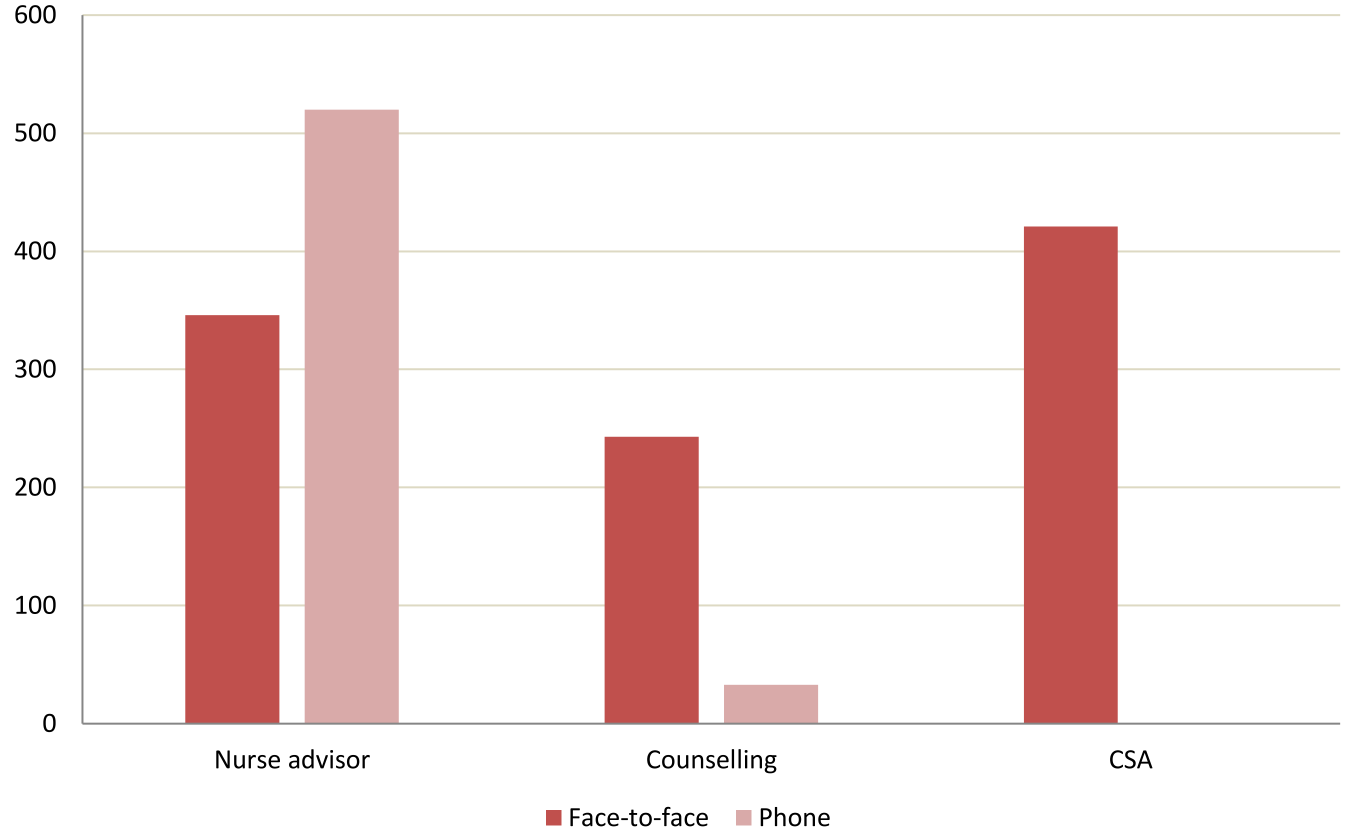
Characteristics		n=	%
Health Board	Aneurin Bevan	**42**	**12%**
	Abertawe Bro Morgannwg	**42**	**12%**
	Betsi Cadwaladr	**74**	**22%**
	Cardiff & Vale	**44**	**13%**
	Cwm Taf	**34**	**10%**
	Hywel Dda	**90**	**27%**
	Powys	**11**	**3%**
Gender	Male	**301**	**89%**
	Female	**36**	**11%**
Marital status	Married	**236**	**70%**
	Single	**48**	**14%**
	Divorced	**7**	**2%**
	Widowed	**17**	**5%**
	Partner	**26**	**8%**
	Separated	**3**	**1%**
Cancer site	Prostate	**281**	**83%**
	Testicular	**11**	**3%**
	Penile	**5**	**1%**
	Breast	**1**	**<1%**
	Other	**10**	**3%**
	Not applicable	***29***	***9%***

From the data provided it was calculated that in total, 332 clients attended 1010 face-to-face appointments (every client had at least one face-to-face appointment) and 204 of those clients had 553 phone appointments. This data is further broken down by the ManVan service accessed in Table 2.2 and shown graphically in Figure 2.1 below. This demonstrates that 520 of the 1563 (33%) appointments were phone appointments with the nurse advisors.

Table 2.2 · Number of client and appointments by ManVan service type

Type of support offered on the ManVan	No. of clients[18]	Appointments			Average appointments per client[19]		
		Total	% face-to-face	% tele-phone	Total	Face-to-face	Tele-phone
Nurse Advisor	244	866	40	60	3.5	1.4	2.6
CSA	241	421	100	0	1.7	-	1.7
Counselling	63	276	88	12	4.4	4.0	2.2
TOTAL	**332**	**1563**	**65**	**35**	**4.7**	**3.0**	**2.7**

Figure 2.1 · Number of Tenovus ManVan appointments by service and mode of contact



Cross referral between the ManVan services appears to work well with over half of clients having appointments with more than one service. 35 clients (11%) had accessed all 3 services and had appointments with the nurse advisor, the counsellor, and the CSA – see Figure 2.2 below.

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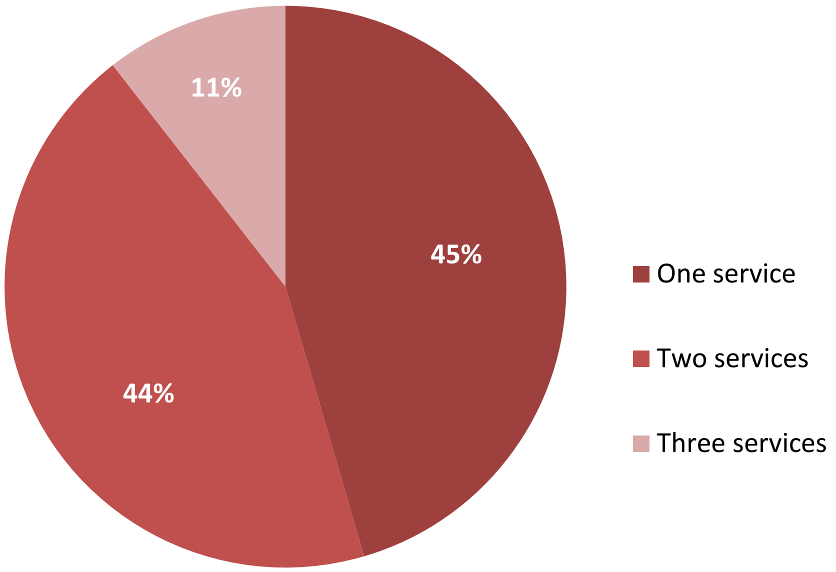
[18] The reason that this number does not equal the sum of the previous rows is that people were able to access more than one form of support.

[19] The averages are based on different numbers of clients for each service, meaning that they don't sum to the total.

Figure 2.2 · Proportion of clients accessing one, two, or three ManVan services



INTERVIEWS WITH CLINICAL STAFF AND MANVAN CLIENTS

The interviews that were conducted with clinical staff and ManVan clients revealed that staff were generally very positive about the services provided on the Van and value what the ManVan offers to men with cancer and their families. The themes from these interviews are explored below, and represented in diagrammatical form in Figure 2.3. Indicative topic guides for these interviews are provided in Appendix I.

Additional capacity

There was recognition by clinical nurse specialists that they may not have the time to answer all patients' questions regarding their diagnosis and treatment, or have the knowledge and expertise to provide welfare benefits advice and formal counselling. The pressure of working in a busy clinic meant that NHS staff did not always feel they had time to explore patients' worries and concerns in as much depth as they would like:

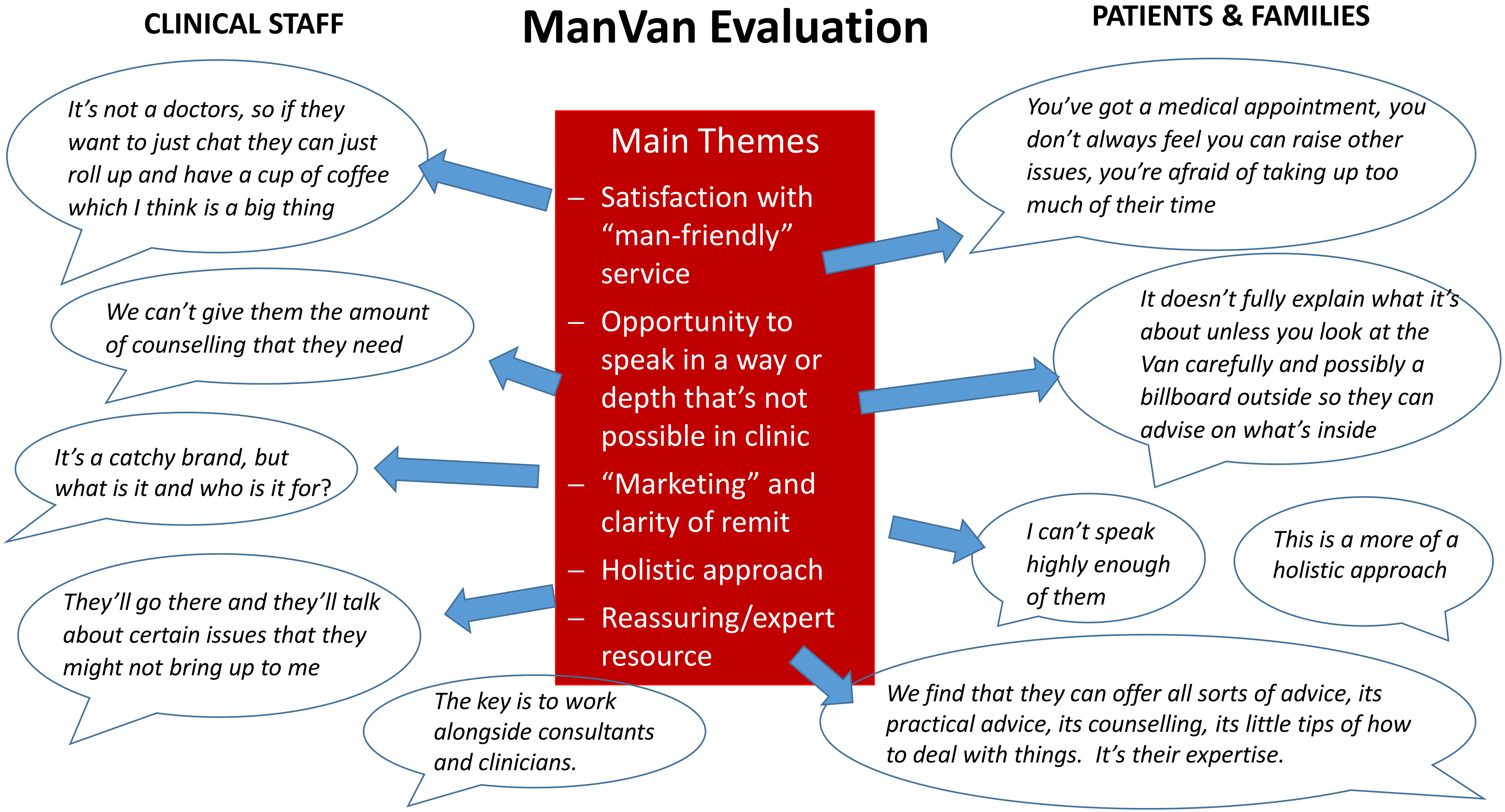
> *"Patients that have their initial diagnosis are incredibly shocked, frightened, frustrated and although we try and support them we can't give them the amount of time that they need. In 20 minutes we're covering their diagnosis, what's going to happen next, all about their disease"*

Clients of the ManVan also acknowledged the time pressures facing clinical staff in the hospital: *"You've got a medical appointment, you don't always feel you can raise other issues, you're afraid of taking up too much of their time"*. In this way the ManVan services compliment those offered in the clinic: *"It's great to have something to do these kinds of things we can't, to compliment the services we provide. We know how stretched we are and this is great to have"*. This was especially true for those staff who had a more clinical role within the healthcare system:

> *"I'm very clinical and I operate in a way like a consultant because I do the biopsies and I'll give the diagnosis and organise the treatment. Really my counselling consists of giving them the diagnosis and sorting them out from a clinical point of view."*

The nurse specialists highlighted that they were not trained to provide welfare benefits advice and were not confident to answer patient queries about their entitlements, particularly at this time when changes are being made to the benefits systems: *"If I needed to find out what benefits my patient was entitled to that would be a morning's work"*. They were reassured that they could signpost patients to the ManVan

Figure 2.3 · Key themes from the interviews



ManVan Evaluation

CLINICAL STAFF

It's not a doctors, so if they want to just chat they can just roll up and have a cup of coffee which I think is a big thing

We can't give them the amount of counselling that they need

It's a catchy brand, but what is it and who is it for?

They'll go there and they'll talk about certain issues that they might not bring up to me

The key is to work alongside consultants and clinicians.

Main Themes

- Satisfaction with "man-friendly" service
- Opportunity to speak in a way or depth that's not possible in clinic
- "Marketing" and clarity of remit
- Holistic approach
- Reassuring/expert resource

PATIENTS & FAMILIES

You've got a medical appointment, you don't always feel you can raise other issues, you're afraid of taking up too much of their time

It doesn't fully explain what it's about unless you look at the Van carefully and possibly a billboard outside so they can advise on what's inside

I can't speak highly enough of them

This is a more of a holistic approach

We find that they can offer all sorts of advice, its practical advice, its counselling, its little tips of how to deal with things. It's their expertise.

where they would be given up-to-date and relevant information about eligibility for benefits and help with the application process: *“We can’t know everything, we can’t know the social services side of things, we don’t know about the benefits and I think its good that they can get that from somebody else”.* NHS staff also commented that referral to counselling on the ManVan is a much quicker process than referring a patient for counselling services in the NHS, which is often done via the GP and patients have to wait for their appointment:

> *“The counselling services in clinic have got a long wait so I think it’s really positive that counselling is done for them more quickly on the van”.*

> *“If they go to the GP and they need counselling it takes a considerable amount of time on the NHS. Whereas the ManVan it’s in a couple of weeks. And that’s immense if you’ve been given a cancer diagnosis.”*

Trusting in independent experts

This confidence in the ManVan team and services has certainly helped establish the service in the successful areas where strong relationships with the clinical team in the hospital exist. The ManVan nurse advisors were trusted and seen as providing another perspective for patients: *“you’ve got an unbiased second opinion”.* Working in conjunction with the clinical team was also crucial for maximising referrals to the ManVan:

> *“We negotiated and co-ordinated it so that I run my prostate cancer clinics on the same day that the ManVan is there. The times were chosen quite deliberately to get maximum footfall through the ManVan”*

> *“Before it wasn’t co-ordinated with the clinic, my consultant colleagues weren’t even aware they were there – at the back of a car park somewhere – it didn’t work well so it’s the logistics point of view. If the van co-ordinates with clinic staff and gets a better placement in hospital. Apparently they were coming to Glangwili and as a consultant I didn’t even know they were there”*

Clarity of offer

Many of the interviewees stated that they did not know about the ManVan or were unsure as to the services it offered and who it was for:

> *“I wasn’t aware that it was coming before it actually arrived. You don’t quite fully understand what it is or what it’s going to do until it arrives and you start to hear what’s going on. I’m much more aware now than I was before which is very useful”*

> *“It’s a very busy clinic and we’ve only been down to the van once or twice, and while the van staff came up to let them know they were parked up, the communication could perhaps be a little better”*

> *“What is it and who is it for? I’ve got to explain this every single time, so I don’t know if there’s a way of getting that across that it’s for men who are worried about prostate cancer. It’s not obvious from the business cards that you give”*

This was linked to the view that clinical staff can signpost and direct patients to the Van, or inform them when it is going to be at the hospital site, but they can’t guarantee that these patients will access the services on-board: *“The Van team don’t wait in the waiting room area anymore and I don’t know how many of our patients that we signpost down there actually make it and how many just head straight out.”*

Interviewees were asked about any improvements that could be made to the service and many suggested that advertising of the Van could be better to raise awareness of the Van and what it offers. Some clients suggested advertising outside the Van when it is parked at a particular site, but it was also acknowledged that if it is too obviously a service for men with cancer this may deter men from going on the Van: *“If it was in somewhere more public would you want everyone knowing? I think you’ve got to be careful from a* *confidentiality point of view as to what they put on it".* Increased promotion of the Van may increase referrals as one study identified in the literature review found that one of the main barriers to the use of cancer support is the lack of awareness, which was found in 25% of men with prostate cancer.[20]

Building on Figure 2.3, the main themes from the evaluation are provided in Table 2.3 below along with a selection of supporting quotes from the interviewees.

Table 2.3 · Themes from NHS staff and ManVan client interviews

Key theme	Evidence
Satisfaction with "man-friendly" service	*The ManVan is quite a unique service that we strongly embrace [NHS Staff]* *Men like vehicles and its quite masculine [NHS Staff]* *…it's guys as well and I'm a female – I think guys one-on-one might talk to each other a bit better about certain things don't they. And it's quite a big macho American style Van so I think it draws them in [NHS Staff]*
Opportunity to speak in a way or depth that's not possible in clinic	*It's not a doctors, so if they want to just chat they can just roll up and have a cup of coffee which I think is a big thing [NHS Staff]* *You go to the hospital and they haven't got that one-to-one, they haven't got time to tell you exactly the detail [ManVan client]* *Giving them the time that we sometimes can't give them in clinic because in our clinic sessions we've got a 10 minute slot to do each patient – they come with so many different problems not just to do with treatment – such as finance, benefits wise - they need lots of time that we can't give them in the clinic [NHS Staff]* *They've got time for people to talk and explain things and the hospital doesn't have that time [ManVan client]* *The biggest benefit of the van and the guys on there is that it's not the hospital, not me and they can probably offload a bit more to them than they will to me because they see me as a clinician. They'll go there and they'll talk about certain issues that they might not bring up to me – I think that's a big benefit [NHS staff]*
"Marketing" and clarity of remit	*I wouldn't have known what it was without the nurse telling me it was coming to Wrexham, it's all about word of mouth and advertisement [ManVan client]* *You don't quite fully understand what it is or what it's going to do until it arrives and you start to hear what's going on [NHS staff]* *I don't know whether a lot of the men don't actually know what it's about. Maybe they should have something outside about how they can help people and financial things. It's that first step into the unknown [ManVan client]* *If it's to target people that are already diagnosed then hospitals make sense. If it's to reach people to encourage them to seek advice then maybe – I know the breast screening van will be in the supermarket car park – if they target that way it will encourage people [ManVan client]*

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[20] Eakin EG, Strycker LA. Awareness and barriers to use of cancer support and information resources by HMO patients with breast, prostate or colon cancer: patient and provider perspectives. Psycho-Oncology 2001; 10:103–104.

Table 2.3 (cont.) · Themes from NHS staff and ManVan client interviews

Key theme	Evidence
Holistic approach	*We find that they can offer all sorts of advice, its practical advice, it's counselling, it's little tips of how to deal with things. It's their expertise. Sometime you don't think of things when you're at the hospital so it's quite useful to have somebody there to bring things up with. It's an informal atmosphere as well [ManVan client]* *It's great to have something to do this kinds of things we can't, to compliment the services we provide. We know how stretched we are and this is great to have. [NHS staff]* *You've got a medical appointment, you don't always feel you can raise other issues, you're afraid of taking up too much of their time. This is a more of a holistic approach. When we went along for the initial chat it was the staff on the ManVan who bought different aspects up – they raised the well-being and the counselling and the financial aspects [ManVan client]*
Reassuring/ expert resource	*They've given us lots of information that we can transfer to our patients [NHS staff]* *We can't know everything, we can't know the social services side of things, we don't know about the benefits and I think its good that they can get that from somebody else [NHS staff]* *We went to the ManVan and they explained everything and put you at ease and the financial side of it he overheard us talking and said that he can deal with any financial problems and it went from there. I can speak to Paul whenever I want, just pick up the phone and they're there for us. There's a room in the ManVan that if I do get upset in there they take me in the room and have a talk [ManVan client]*

3. DISCUSSION

In this section of the report, we reflect on some of the most important challenges that have come from our evaluation, building on the issues raised in chapters 1 and 2, and linking those to the literature and a number of other factors that need to be considered in respect of the service overall. It is important to note at the outset that the ManVan service has learned a considerable amount about what works and what doesn't in delivering this service. Unfortunately, it has not been able to implement this learning as effectively as it might have given the contractual constraints under which it is operating.

REMIT OF MANVAN

There are a series of considerations about the remit of the ManVan, however it is important to note the contractual constraints of the ManVan service which meant that Tenovus were unable to refine the service as it evolved. There was discussion about its potential role in raising awareness of male cancers, whilst recognising that its purpose is to provide the nursing, CSA and counselling sessions to those with a diagnosis, rather than those seeking information. It is the case that ManVan staff do not, of course, refuse to engage with and speak to people who have pre-diagnosis concerns, and in many ways the Van itself is designed to attract attention, which indeed it does. However its remit, at the moment, remains on the survivorship function for those men with a confirmed diagnosis for which funding was provided by Movember. This focus of the ManVan specifically on men *diagnosed* with cancer has also been questioned. Could the van be used to provide health checks in the community, or a mix of health check days and cancer support team days in the successful sites? If different activities take place on different days could this cause confusion about the remit of the ManVan amongst the public?

Should the Van stay focused on diagnosed prostate, penile and testicular cancer patients only or open out the service to all men affected by cancer? This would increase the number of potential referrals to the ManVan although the need for the specialism of the urological cancer nurse specialists would be reduced. This would also require the development of a new set of relationships with healthcare professionals at hospital sites to promote the Van and its services. ManVan staff do not currently turn away men with diagnoses of other cancers but this activity is not formally recorded. Men are less likely to access cancer information and support services in general, as our Tenovus staff interviews suggested, and there are relatively low numbers of male referrals to Tenovus counselling services generally (20% male). Are these men also being poorly served, and would extending the ManVan offer to all male cancers be one way of addressing this? Tenovus have reported that the proportion of men accessing Tenovus cancer support services has increased to 40%, which may be a result of the ManVan activity.

This point is reflected in the findings from one study where men were less likely to regard formal counselling sessions as an important service development.[21] The number of potential referrals is further limited by the ManVan remit of specific cancer sites. Much of the literature demonstrates that fewer men than women access information support services. An evaluation of a welfare rights advice service for patients with cancer reported that of the 1174 individuals seen over a year 45% were male, although the site of cancer was not reported.[22] 40% of contacts at a mobile cancer information and support unit were male, with prostate cancer being the most common cancer amongst visitors with a diagnosis.[23]

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[21] Manning, D.L. and Dickens, C. (2007), Cancer Information and Support Centres: fixing parts cancer drugs cannot reach. European Journal of Cancer Care, 16: 33–38.

[22] Moffatt S, Noble E, White M. (2012). Addressing the financial consequences of cancer: Qualitative evaluation of a welfare rights advice service. PLOS ONE 7(8): 1-10.

[23] Foster C., Scott I. & Addington-Hall J. (2010) Who visits mobile UK services providing cancer information and support in the

In addition, a majority of enquiries to the mobile information unit related to prevention, with questions about screening, exercise, diet and stopping smoking. Over the course of the ManVan evaluation questions were raised about providing treatment on the ManVan or PSA testing:

> *…will it end up being like the mammogram, maybe that's what they should aim at? Doing biopsies or PSA tests* [NHS staff]

STAFF MIX

It was generally agreed that the way in which the counselling service runs is not effectively aligned with the current ManVan schedule. On a practical level it is extremely challenging to provide 6-weekly, fortnightly, or even monthly counselling sessions due to the location of the ManVan in a calendar month. Staff also noted an increased demand for one-off 'therapeutic conversations' lasting between 1 and 2 hours as many men do not want to, or need to, commit to a schedule of formal counselling sessions.

Referrals to the counsellor have also been below expectations in certain sites which may be related to views of NHS staff about the counselling service:

> *Psychological support is a bit more difficult for people to grasp. Nurses think they're counsellors and there are also psychologists in health boards as well. We're somewhere in the middle and it's about getting both levels to engage with us*.

Whereas nurses haven't been explicitly trained to provide benefits advice either, many of them may see themselves – rightly or wrongly – as being able to meet the psychological support needs of patients. Some of the clinical staff who took part in an interview mentioned that there are counsellors and clinical psychologists within the health board who they can refer cancer patients to. However, these counsellors are seen as being only for patients with the most severe psychological needs:

> *When people get in the realm of having significant psychological problems, we've now got funded by Macmillan a clinical psychologist who we've had for about a year – it's all cancer – any patients who have got serious mental health problems with their diagnosis we refer them*

The counsellor is currently on the Van for two days per week. Is there an option to use existing counsellors or sessional counsellors in the areas where referrals are good so as not to miss the drop-in therapeutic conversations and also to hold regular counselling sessions? For example in Carmarthenshire and North Wales where there are fewer psychological support services for patients compared to in South East Wales, it was suggested that this might work effectively: *"We do have counselling on the mobile units and we're in the same locations every week and it runs alongside an existing treatment service. In [location], [the sessional counsellor] has 6 people booked in to see her every week on a Tuesday."*

A further benefit of using existing local multidisciplinary cancer support teams to a greater extent than is currently the case would be to reduce travel costs for ManVan staff. It might also ensure that they do not become demoralised by trying to develop relationships and services in areas where they have had struggles:

> *I think they've almost got that promotion fatigue. They've been travelling around a long time now and it does drain you. The 'Unable Ta Attend' and 'Did Not Attend' rates for the counselling and benefits advice is quite high.*
>
> *At the beginning there were a few more ''bells and whistles" and everybody was trying really hard to make it work successfully – now, it's a bit like "the van's in the car park and there you go" [NHS staff]*

Also consider maximising the use of volunteers either on the van or in the clinic, as at Prince Charles hospital. The volunteers could work as an access point for patients into Tenovus services, providing

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community? European Journal of Cancer Care 19, 221–226.

information about Tenovus and the ManVan schedule in clinic waiting rooms, as seen in other cancer information and support services.[24]

Many of the clinical staff interviewed suggested that the day of the clinic appointment is not always the right time for men to go on-board the ManVan. They may have been in the clinic a long time and have received lots of information about their cancer and/or treatment in the clinic and many men want to go straight home after their appointment.

COSTS AND ACTIVITY

According to the best data available, in 2015[25] the ManVan cost £176,204 to run, staff, and maintain, an average monthly cost of £14,684.[26] There were 169 'active' days for the Van in 2015, when the Van was delivering services at a variety of different locations across Wales, at a cost of £1042.63 per active day (see Table 3.1).

Table 3.1 · Activity by month and Health Board - 2015[27]

Health Board	Actual 7-month active days	Actual 7-month active days – as % of total	Extrapolated 12-month active days	Extrapolated 12-month mean active days per month
Aneurin Bevan	6	6.1	10	0.9
Abertawe Bro Morgannwg	12	12.2	21	1.7
Betsi Cadwaladr	22	22.4	38	3.1
Cardiff and Vale	18	18.4	31	2.6
Cwm Taf	9	9.2	15	1.3
Hywel Dda	26	26.5	45	3.7
Powys	5	5.1	9	0.7
TOTALS	**98**	**100.0**	**169**	**14.1**

During this period there were 214 clients and 856 appointments recorded in the database, at a cost of £205.85 per appointment.[28] The clients were drawn from across Wales as shown in Table 3.2 and the appointments were split by the different ManVan services as shown in the previous chapter in Table 2.2.

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[24] Kinane, NA. (2012). Evaluation of a hospital-based cancer information and support centre. Supportive Care in Cancer, 20: 287-300.

[25] This section of the discussion will focus on data from 2015. It is the only full year for which data is available although, as will be made clear below, some of the data is imperfect in its quality.

[26] Source: Tenovus Cancer Care: Profit and Loss Report, April-December 2015; and April-March 2015. The total expenditure for the year was calculated using the final row in the reports labelled 'total expenditure' to calculate the total for the year.

[27] The 2015 total was extrapolated from the recorded activity reported.

[28] It should be noted that no information is kept about the length of these appointments which does not allow for any more fine-grained understanding of their cost. It is also important to say that not all appointments are formally recorded in the database – people dropping onto the Van for information, for example, are not recorded, nor are those who have a different diagnosis of cancer outside of prostate, testicular or penile.

Table 3.2 · Clients by Health Board - 2015

Health Board	Total clients	Total clients – as % of total
Aneurin Bevan	20	9.3
Abertawe Bro Morgannwg	22	10.3
Betsi Cadwaladr	52	24.3
Cardiff and Vale	28	13.1
Cwm Taf	18	8.4
Hywel Dda	68	31.8
Powys	6	2.8
TOTALS	**214**	**100.0**

In order to bring all of these elements together, Tables 3.3 and 3.4 connect the overall activity with the varying costs for that activity in each of the health boards. It demonstrates a pattern of some considerable variation across Wales. This variation could be explained by a number of different factors, although it has not been possible to be definitive about these.

That said however, this does present a mis-match between inputs and outputs in the system, in purely activity terms. There are certain health boards, for example, where per appointment costs are relatively low but overall activity has been low (like Cwm Taf), whereas for others, activity has been much higher but cost have also been relatively high too (like Cardiff and Vale). The best case is represented by places where activity is high and costs are relatively low (like Hywel Dda) and the worst case is where activity is low and costs are high (like Powys). This is represented in Table 3.4 by considering the difference between the proportion of spend and the proportion of appointments.

Further to the variation in terms of overall activity and cost by Health Board, Table 3.3 also points to significant variation in the use of face-to-face and telephone appointments. Overall however (and even though this varies between the three services) around one third of the recorded activity undertaken by staff in the Van for 2015 took place over the telephone.

LOCATIONS

Closely linked to the consideration of the variance in activity and costs are a series of considerations around the locations used by the ManVan. Put simply, is there a continuing case for going to the sites where referrals are historically low and per appointment costs are accordingly high at the expense of increasing the offer to areas where NHS staff are fully engaged with the ManVan? For example, in June 2015, of the 21 new clients, 12 were from Hywel Dda, 5 from Betsi Cadwaladr, 2 from Aneurin Bevan, 1 each from Cwm Taf and Abertawe Bro Morgannwg, with no new clients from Cardiff & Vale or Powys. ManVan appointments in 2015 from Hywel Dda and Betsi Cadwaladr account for nearly 50% of the total, which has lead to pressure being put on ManVan staff that was never envisaged:

> *We should never have done all of Wales with one van and with one team. North Wales was a surprise but the numbers up there are fantastic. Because of the uptake we're up there every month and that's affected the budget and other things.*

Table 3.3 · ManVan activity by Health Board – 2015[29]

Activity	Aneurin Bevan	Abertawe Bro Morgannwg	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf	Hywel Dda	Powys	**TOTAL**
Nurse advisor face-to-face appointments (n)	15	15	63	26	15	71	4	**209**
Nurse advisor phone appointments (n)	21	32	58	47	26	80	6	**270**
Counsellor face-to-face appointments (n)	29	8	7	12	40	24	0	**120**
Counsellor phone appointments (n)	0	0	1	0	2	1	0	**4**
CSA face-to-face appointments (n)	33	24	49	29	31	81	6	**253**
TOTAL Face-to-face appointments	**77**	**47**	**119**	**67**	**86**	**176**	**10**	**582**
TOTAL Telephone appointments	**21**	**32**	**59**	**47**	**28**	**81**	**6**	**274**
TOTALS	**98**	**79**	**178**	**114**	**114**	**257**	**16**	**856**
Extrapolated active days[30]	10	21	38	31	15	45	9	**169**
Mean appointments per client (n)	5.8	5.2	4.2	3.3	2.9	3.7	2.2	**4.0**
MEAN NO. APPOINTMENTS PER ACTIVE DAY	**9.8**	**3.8**	**4.7**	**3.7**	**7.6**	**5.7**	**1.8**	**5.1**
OVERALL – FACE-TO-FACE APPOINTMENTS (%)	**78.6**	**59.5**	**66.9**	**58.8**	**75.4**	**68.5**	**62.5**	**68.0**
OVERALL – TELEPHONE APPOINTMENTS (%)	**21.4**	**40.5**	**33.1**	**41.2**	**24.6**	**31.5**	**37.5**	**32.0**

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[29] Based on 214 clients on database for 2015.

[30] See Table 3.1 for details.

Table 3.4 · ManVan costs by Health Board – 2015[31]

Activity	Aneurin Bevan	Abertawe Bro Morgan'wg	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf	Hywel Dda	Powys	**TOTAL**
Mean cost per active day (£)[32]								**1042.63**
Costs for active days (£)	10426.30	21895.23	39619.94	32321.53	15639.45	46918.35	9383.67	**176204**
TOTAL Costs per appointment (£)	**106.39**	**277.15**	**222.58**	**283.52**	**137.19**	**182.56**	**586.48**	**205.85**
OVERALL – PROPORTION OF SPEND (%)	**5.9**	**12.4**	**22.5**	**18.3**	**8.9**	**26.6**	**5.3**	**100**
OVERALL – PROPORTION OF APPOINTMENTS (%)	**11.4**	**9.2**	**20.8**	**13.3**	**13.3**	**30.0**	**1.9**	**100**

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[31] Based on 214 clients on database for 2015.

[32] Calculated by dividing the total cost for 2015 of £176,204 by 169 extrapolated active days.

Most mobile services aim to provide care closer to patients homes, which is an important factor in patient satisfaction with mobile cancer support services and indeed was one of the key justifications for the ManVan service at the outset.[33,34] As was the need to provide services closer to areas of socio-economic deprivation. However, the siting of the ManVan at hospitals means patients still have to travel to those locations and pay for the associated travel and parking costs:

> *We had appointments at the time so it fell in quite well. If not, then it would be quite a trek. It's about 10 miles away so on a day-to-day basis it's not the best location [ManVan client]*
>
> *It's outside the hospital, the only thing is the parking for people – it doesn't matter what time you go, it's horrendous and that puts people off. If you do get a space you're only allowed for it an hour. It's in a really good spot it's just the parking. We're lucky because my son can drop us off outside. [ManVan client]*

The numbers of patients with the three cancers that ManVan currently supports have not been sufficiently numerous to make anything other than hospital sites really viable locations for the Van – when it is parked in community locations, the throughput of appointments is low. This would however, be the preferred model, so is there an argument for increasing the number of potential clients by increasing the number of male cancers that could be supported by ManVan staff such that parking the Van in community venues and not losing the throughput becomes a more realistic option?

One study from the Netherlands found travel distance influenced interest and participation in prostate cancer support groups.[35] The literature review above also suggested that the use of telephone support may be particularly welcomed by men with cancer. A study of men with cancer living in rural Australia found that highest rates of participation in a support service were for cancer organisations that offer support via telephone or the internet.[36] This type of support offers the opportunity for easy and anonymous access, where factors like geographic isolation, physical limitations and discomfort with face-to-face approaches make seeking formal support difficult.

In a study that investigated the use of telephone-based decision support for men newly diagnosed with prostate cancer, a high level of satisfaction with the intervention was reported, as were the benefits of using a service that was accessible and anonymous.[37] Seeking support anonymously avoids any stigma attached to seeking help for an emotional problem, concern over which has been found to be higher among rural residents than among urban residents.[38] As such, and as per the evidence,[39] should there be a consideration of whether the proportion of telephone calls made by ManVan staff (and potentially others) could increase for certain men in Wales?

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[33] Iredale, R., Hilgart, J. and Hayward, J. (2011), Patient perceptions of a mobile cancer support unit in South Wales. European Journal of Cancer Care, 20: 555–560.

[34] Mitchell T. (2013) Patients' experiences of receiving chemotherapy in outpatient clinic and/or onboard a unique nurse-led mobile chemotherapy unit: a qualitative study. European Journal of Cancer Care, 22(4):430-439

[35] Voerman B, Visser A, Fischer M, Garssen B, van Andel G, Bensing J. Determinants of participation in social support groups for prostate cancer patients. Psycho-Oncology 2007; 16: 1092–1099.

[36] Corboy D, McLaren S, McDonald J. Predictors of support service use by rural and regional men with cancer. Aust. J. Rural Health 2011; 19, 185–190

[37] Steginga S, Ferguson M, Clutton S, Gardiner RA, Nicol D. Early decision and psychosocial support intervention for men with localised prostate cancer: an integrated approach. Supportive Care in Cancer 2008; 16: 821–829.

[38] Hoyt DR, Conger RD, Valde JG. Psychological distress and help seeking in rural America. American Journal of Community Psychology 1997; 25: 449–470.

[39] See Corboy D, McLaren S, McDonald J. Predictors of support service use by rural and regional men with cancer. Aust. J. Rural Health 2011; 19, 185–190

VALUE FOR MONEY

> *What impact would that have if we stopped the service as it is? I don't think it would have a huge impact. We've got an existing cancer support team across Wales and a Van stopping going to limited locations...the impact would not be that massive. The only thing to be missed would be the opportunity to do other stuff with that Van.*

The quotation above is stark in its candour. Would anyone miss the ManVan service if it stopped? The short answer is yes, of course. There are men and the families across Wales who have been effectively supported by staff whose lives have been changed significantly for the better after their involvement with ManVan staff – whether emotionally, clinically, financially or all three in combination. It would be churlish to suggest otherwise.

That said, there are questions over the economics of the current service model. The initial cost of the vehicle and refit was £120,000. Is the ManVan cost-effective under the current service model, the current number of appointments whether with new or existing clients, and the amount of work with clients that is currently conducted over the phone and could be undertaken off-Van? Although the figures quoted in this report do not take into account the number of people who drop-in to ManVan for informal clinical conversations with nurses, or those people who do not fit the ManVan remit, such as men with other cancers, consideration needs to be given as to whether the ManVan provides value for money. For example, the nature of the current provision where the number of drop-ins varies considerably from day-to-day, DNA and UTA rates also vary, and unreliability of internet access and phone reception limits case work that can be done on board. Is it worth the cost for the opportunistic appointments and contacts? There is only one private room for pre-booked appointments. Does this affect the number of appointments that can be provided on the van?

In 2013, there were 2634 new diagnoses of prostate cancer in Wales, and 95 men in Wales were diagnosed with cancer of the testes. In 2015, the ManVan saw 214 new clients. This suggests that if the number of newly diagnosed men with these cancers has stayed constant, the ManVan is reaching about 1 in every 12 newly diagnosed men.[40] Is there scope, using some of the detail above to re-think the model, for the ManVan to reach more of these men?

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[40] Accepting, of course, that not all new clients are newly diagnosed.

4. CONCLUSIONS

In this chapter, some reflections are offered, areas for further consideration identified, and comes to five concrete conclusions about the ManVan.

It is useful to remember something about the data on which the analysis below is based. The researchers undertook a relatively small mixed methods study, combining both qualitative and quantitative approaches to the evaluation. These methods included undertaking in-depth interviews with clients and stakeholders, and an analysis of the data currently gathered by the project team.

REFLECTIONS

The twin challenges of geography and throughput

There are perhaps two key measures of success for the ManVan. One is that the ManVan has successfully reduced the amount of travel time/distance needed to access the kind of support that the Van offers. This issue about inequality of access is a key goal for the Van. The trade off is that in order to achieve outreach into places that are not well served by the Van, means that the Van has had to locate in places where the footfall is not as great as it is in others. The second key measure therefore is whether you have reached as many people as you could have and offered them the opportunity of coming onto the ManVan. And these things operate to a degree in tension. The data above demonstrates that it is very difficult to achieve both. So the question that follows is: do you ensure greater equity of access, or do you say that we need to prioritise footfall?

We may hypothesise that the 'sphere of influence' of the Van is something like 15 miles i.e. people are prepared to travel that far for ManVan services but not further. If we then change the number of outreach sites such that for a greater proportion of the Welsh population the ManVan is now beyond the 15 mile limit, then that change of model would have the effect that it was denying access to the service for some people.

The flipside of that is that if you were to concentrate on the core sites (as defined by footfall and good relationships with staff) you might then argue that that model has the potential to achieve greater equality of access. There would then be a large number of people who want to access the Van and who previously couldn't because it's only there once a month but if it were there twice a month then they could. For this number of people whose need are currently unmet, their needs would then, in effect, be met. Even though in this model the ManVan wouldn't see people who are no longer willing to travel, it is probably the case that the productivity of the ManVan would increase and that the service would be better optimised.

So, a choice between models – do you continue to operate the 'outreach' model which works at higher cost and lower capacity, or do you transition to the 'core' model which may be able to operate at higher capacity and potentially lower cost?

Overall, is the ManVan the right resource when so much of the kind of support can be offered to people remotely, especially when they may prefer the anonymity offered by the internet and telephone consultations? The support may well be better in person and there is certainly something to say for the opportunistic moment of being there and speaking to someone, and certainly value in having a nurse/counsellor/CSA offer in one place at one time (the perfect one-stop shop as it might be described) but is this better than just relying on existing resources and remote forms of support? It is very difficult to be definitive about an answer to this question, largely based on the fact that the data used to support this conclusion is far from perfect.[41]

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[41] Appendix II provides a list of the data that was requested – although unfortunately not all was available to the evaluators.

OPTIONS AND AREAS FOR FURTHER CONSIDERATION

However, taking the limitations of the dataset and the scale of the evaluation into consideration alongside the issues in the discussion chapter, Table 4.1 provides both a series of options for the ManVan and considerations to go alongside them. The list is by no means exhaustive, and should be seen in the context of the evidence gathered in this study.

Table 4.1 · Options and considerations for the ManVan

Option	Considerations
Option 1 **Expanding to all male cancers and not limited to prostate, testicular and penile cancer**	– Increase potential referral numbers and be eligible for more funding – Men with other cancers are not turned away currently anyway – Nursing advisors would need to be more general – New relationships with healthcare professionals would need to be developed
Option 2 **Develop health and well-being days as part of the Van's offer**	– Fits with original idea and vision, although not necessarily focused on those with a diagnosis which would have implications for funders – Aware of demand for service and maybe increase number of visitors – Already have visitors without diagnosis of cancer 'the worried well' which doesn't contribute to van activity numbers – Could include education about PSA testing and other cancer screening which is line with the *Cancer Delivery Plan*[42] aims to raise public awareness of cancer symptoms and promote better take up of screening – Health and well-being days are also in line with the *Cancer Delivery Plan* which aims to promote better public awareness of cancer risk factors and encourage participation in health checks for people aged over 50 to facilitate access to relevant, clear and consistent health advice.
Option 3 **Consider the role of counselling as part of the offer**	– Currently counsellor only on Van two days a week – Viability of regular counselling appointments in current model of provision? – Increase offer of therapeutic conversations for men with option of traditional counselling sessions, thereby ensuring more of this activity is measurable and counted
Option 4 **Use Van as a gateway to other support services but less as a delivery vehicle**	– Much of the work could be done remotely via telephone – Increase use of volunteers – Publicise to get more male referrals to other services – Limited space for pre-booked appointments on the Van – Reduce impact of DNA and UTA on activity

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[42] Welsh Government, Together For Health – Cancer Delivery Plan: A Delivery Plan up to 2016 for NHS Wales and its Partners http://gov.wales/docs/dhss/publications/150427planen.pdf

Table 4.1 (cont.) · Options and considerations for the ManVan

Option	Considerations
Option 5 **Increase use of other regional staff**	– Reduce staff travel costs – Fresh team in each area – Continuity of service delivery in communities – Provision of regular counselling sessions

DRAWING THE EVIDENCE TOGETHER...

Overall, the ManVan has delivered a professional and valued service to a number of men in Wales over the last two years. The services values of being approachable, empathetic and supportive have ensured that it has, in certain parts of Wales, become well-respected. A key challenge is that the ManVan has not been able to achieve this success universally and as such the impact and cost of the service has varied across Wales.

One The ManVan is currently working under-capacity in more than half of Wales' Health Boards.

Two The service model is not consistent with how some services need to be delivered

Three The ManVan 'mode' of working is inefficient, as it has not proved possible to maintain a constant throughput of people who want to access support face-to-face on the Van, like for the nursing appointments.

Four The significant overheads of running and maintaining the vehicle mean that it is a costly way of providing such support.

Five As a pilot and 'proof of concept' the ManVan has much to recommend it – it has worked for many people. It is apparent that these people could have accessed similar forms of support in other ways.

APPENDICES

APPENDIX I · **NDICATIVE TOPIC GUIDES**

BENEFICIARIES AND THEIR FAMILIES

The following list of questions provides an indication of the areas that we would seek to cover during in-depth interviews with survivors and their families. They are presented in no particular order here, and in practice would be augmented by a series of additional questions to gain further insights and perspectives. They are grouped together under certain key headings, which mirror the important perspectives about which we need to hear. Not all questions will be applicable in all circumstances.

Accessing services	How did you find out about the Man Van? Why did you choose to go on the Man Van? What are the advantages and disadvantages of a mobile unit from your point of view? What difference does it make having access to local support and care? Why? What features and services of the Man Van do you value the most? Why?
Impact on you	What impact has it made in respect of the following aspects of your survivorship: – practical (finance, housing etc.) – emotional (feeling anxious or depressed etc.) – communication (quality, quantity and clarity of information etc.) – physical (general health and well-being etc.) What are the consequences for you of having used the Man Van? To what extent are you better equipped to deal with surviving cancer after visiting the Man Van? What is your view about the role of such mobile services for you and others like you?
Changes?	What else could/should be offered? To what extent has the Man Van provided the right balance of the kinds of support that you need to help you in surviving your cancer?
Overall	What did the Man Van offer that you couldn't have received in any other way? What does the Man Van do better or worse than more traditional forms of care and support? To what extent would you agree or disagree that the Man Van offers an opportunity to help with your survivorship that you would not have received otherwise?

NHS STAFF AND OTHER STAKEHOLDERS

The following list of questions provides an indication of the areas that we would seek to cover during in-depth interviews with other stakeholders including NHS professionals. They are presented in no particular order here, and in practice would be augmented by a series of additional questions to gain further insights and perspectives. They are grouped together under certain key headings, which mirror the important perspectives about which we need to hear. Not all questions will be applicable in all circumstances.

Service model	What do you know about the Man Van? What is your view about mobile services like these? What is the nature of the relationship between more traditional NHS forms of delivery and these innovative service models? What are the barriers and enablers to successful partnership working? What could be done to improve the nature of the services provided on the Man Van? What else could/should be offered? What features and services of the Man Van do you value the most? Why?
Impact	What impact has the Man Van had on survivors and their families? What are the specific therapeutic, well-being and self-efficacy outcomes of the Man Van? What are the overall health benefits of a service like this? What might the potential impacts on service delivery be of the Man Van service? Are there any resource implications?
Overall	What does the Man Van offer that you the NHS can’t provide in any other way? What does the Man Van do better or worse than more traditional forms of care and support? What, if any, reservations do you have about the Man Van? Why?

APPENDIX II · **DATA REQUESTED FROM MANVAN**

ManVan service data

Please could you supply the following data items, each of which disaggregated by age/ethnicity/ManVan site/stage of cancer journey, supplied by quarter for the whole period of data capture:

- Total no. of **people** who visit the ManVan for general health and well-being advice
- Total no. of **people** supported by the ManVan, and of these:
    - No. of people supported **face-to-face**
    - No. of people supported **over the telephone**
    - Proportion of people supported who have a confirmed diagnosis of prostate/testicular/penile cancer
- Total no. of **appointments** undertaken by ManVan staff, and of these:
    - No. of appointments undertaken **face-to-face**
    - No. of appointments undertaken **over the telephone**
    - Proportion of appointments with people who have a confirmed diagnosis of prostate/testicular/penile cancer
- Total no. of **appointments** missed, and of these:
    - No. of UTAs
    - No. of DNAs
    - And the extent to which these vary by different staff members

ManVan costs

- Total expenditure of the ManVan to date, split into the following components:
    - Initial cost of vehicle
    - Cost of vehicle – upkeep
    - Cost of vehicle – fuel/mileage
    - Staff costs – nurse/counsellor/benefits adviser/driver
    - Staff expenses
    - Other costs

Other data

- Assessment of the extent to which ManVan staff are working at full capacity
- Capacity/costs of the health board-located Multi-Disciplinary Teams

Welsh Institute for Health and Social Care

University of South Wales, Glyntaf Campus, Pontypridd, CF37 1DL
wihsc.southwales.ac.uk · wihsc@southwales.ac.uk · 01443 483070