

Working Document

Five year

Cancer commissioning
Strategy for London



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Five year Cancer Commissioning Strategy for London

A. Executive summary

Every year more than 30,000 Londoners will receive a cancer diagnosis¹. As treatments and care improve, greater numbers of people are living with and beyond cancer. In London the number of people living with and beyond cancer is more than 200,000 and this is expected to double by 2030².

Cancer and how it is managed is therefore changing as treatments advance and survival rates increase; for many patients, cancer is a condition they live with and manage on an on-going basis similar to other long term conditions. Despite the fact that more people are surviving cancer than ever before, mortality and survival rates vary significantly between London boroughs: fourteen London CCGs have lower one year survival rates than the England average mortality rates than the England average³. Cancer is the second leading cause of death across the capital and this rises to the leading cause of premature [or under 75] death⁴.

London is a world class city with the aim of being the “best big city in the world⁵” and yet it cannot currently claim world class cancer outcomes nor can it claim to care for cancer patients in a way that puts them and their needs first.

Patients in London are still diagnosed when their cancer is at a later stage than European counterparts meaning successful treatment is less likely. Across the capital, between 25 and 30per cent of cancer diagnoses are made in Accident and Emergency (A&E). Late stage cancers can impact the type of treatment available to the patient: for example resection rates for lung cancer are dependent on the tumour being at an early stage.

Furthermore, variation in care and treatment following diagnosis can lead to poorer patient outcomes and patient experience. Simply reviewing the length of stay and readmission rates for colorectal cancer patients across London paints a picture of the enormous variation in patient experience and outcomes depending on where an individual is diagnosed, receives treatment and follow up care⁶.

The National Cancer Patient Experience Survey brings home the extent of reported poor patient experience, with nine out of the 10 worst reported hospitals for cancer patient experience being in London – a position London holds year on year⁷.

¹ 2012 data, Encore Cancer Analysis System

² Estimated for London (SHA) based on population estimates and Maddams J, Uttley M, Moller H. Projections of cancer prevalence in the United Kingdom, 2010 – 2040. British Journal of Cancer 2012; 107: 1195-1202. Figures exclude non melanoma skin cancer'

³ Cancer Research UK Local Statistics: Data from [ONS/ London School of Hygiene and Tropical Medicine](http://www.ons.gov.uk/ons/2010/01/01/london-school-of-hygiene-and-tropical-medicine) (2010)

⁴ As documented in London borough Joint Strategic Needs Assessments

⁵ Boris Johnson's aim for London <http://www.london.gov.uk/mayor-assembly/mayor>

⁶ Please see Reducing Variation and Service consolidation section of the strategy

⁷ <http://www.macmillan.org.uk/Documents/AboutUs/Research/Keystats/2013CPESInsightBriefingFINAL.pdf>

Despite great progress in implementing the 2010 *Model of Care*⁸, there is more we can do to ensure implementation of the recommendations is accelerated. Additionally since the development of the *Model of Care*, new evidence and developments have been made to inform national thinking on issues such as the early detection of cancer and supporting patients after cancer treatment. Taking the two elements into account, London should be able to drive up cancer outcomes to match best in world and that all Londoners, no matter where they live in London, receive excellent care.

This refresh and re-state of the *Model of Care* provides a five year vision and sets out the priorities across London for transforming cancer services.

For London to make a demonstrable improvement in transforming cancer services – improving outcomes and patient experience – public health teams, CCGs, NHS England, the Integrated Cancer Systems and the voluntary sector will need to work together in a new way. This will be a challenge but is deliverable.

⁸ <http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Cancer-model-of-care.pdf>

B. Introduction

In 2009, the *Case for Change*⁹ identified many of the challenges facing London's cancer services:

- late diagnosis of cancers with many cancers diagnosed at a late stage when successful treatment is less likely;
- variability in cancer outcomes across London for common cancers;
- variability in cancer outcomes across London for rare and more complex cancers;
- poor patient experience: nine of the ten worst providers in England for patient experience are in London and this has not changed since 2009; and,
- rising costs of cancer care (which more recent modelling estimates the total cost associated with patients receiving cancer services to be around £2.2bn and rising).

The *Model of Care* was subsequently developed in 2010 by London's cancer community and proposed robust, clinically-led solutions to enable improvements to be made in the capital's cancer services.

Setting out 104 recommendations across 13 care pathways, the *Model of Care's* key recommendations were to:

- Help diagnose cancer earlier
- Improve patient care and reduce inequalities in access to and uptake of services
- Improve patient outcomes
- Improve patient experience.

Since 2010, London's providers and commissioners have worked to implement the recommendations set out in the *Model of Care*. Significant changes have included the development of the two integrated cancer systems – London Cancer and London Cancer Alliance - which bring together London's 28 acute and tertiary care providers cancer providers to deliver coordinated and integrated care along the whole patient pathway.

April 2013 brought changes to the NHS with new commissioning arrangements:

- CCGs have responsibility for the commissioning of common cancer services as well as early diagnosis, services for patients living with and after cancer as well as end of life care.
- NHS England has responsibility for the direct commissioning of specialist services including chemotherapy and radiotherapy, primary care and cancer screening.
- Public Health teams within Local Authorities take on responsibility for prevention and population awareness of cancer signs and symptoms.

⁹ <http://www.londoncancer.org/media/11798/cancer-case-for-change.pdf>

Three years into delivering the *Model of Care*, costs are escalating, budgets are becoming tighter and patient experience remaining stubbornly poor. Having a clear, refreshed cancer strategy will ensure that progress on implementing the *Model of Care*, and new developing cancer improvements, is accelerated. It will be critical that this is underpinned with an understanding of how commissioners will need to commission different aspects over the five years, and any significant investments that may be required or savings that may be achieved through the implementation of this strategy.

This restatement of the *Model of Care* sets out proposed priorities for commissioners over the next five years. It needs to be reiterated that the *Model of Care* still stands and progress is expected to continue implementation of the recommendations. This refreshed strategy reflects those areas of importance for all commissioners and it is hoped commissioners will rally behind in order to transform cancer outcomes.

The strategy sets out an assessment of proposed interventions prioritised against:

- patient outcomes;
- patient experience; and,
- readiness of each intervention for implementation.

A full summary of the recommendations can be found at the end of the strategy document. It will be for commissioners to determine how, and from whom, they wish to commission services on behalf of their patients. Further modelling work is currently being undertaken to support investment decisions and local evaluation and implementation plans will need to be developed.

By setting out a five year view of the priorities for cancer, the strategy aims to make the compelling case for transforming cancer services across London so that every Londoner receives a world class experience from prevention, through early detection to treatment, subsequent support and to end of life care. In this way, it is believed more than 1000 extra Londoners' lives can be saved.

<p>This strategy is a refresh of the <i>Model of Care</i> which also includes new evidence and sets out new developing ideas setting out the compelling case for commissioners to support the transformation of cancer services across London.</p>
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Developing the strategy

Discussion at meetings of the Cancer Commissioning Board (CCB) and the Cancer Clinical Leadership Advisory Group (CCLAG) have reiterated the importance of having a strategic and planned approach for cancer to enable decision making by commissioners to support the delivery of the *Model of Care* and further proposals to support the transformation of cancer services in London. This will ensure that the *Model of Care* implementation is conducted in an appropriately phased way over a two to five year period and that new recommendations for improvement are built into commissioner and provider plans.

At the same time, NHS England's *The NHS belongs to the people: A Call to Action*¹⁰ has launched. This is a public, staff and stakeholder consultation to determine NHS priorities (across all disease areas) moving forward in order to meet rising demand and expectations of the NHS. This plan for cancer will align with the national *Call to Action* work, ensuring that the importance of bringing about improvements in cancer services across London is recognised as a priority with all key stakeholders, including new commissioning organisations.

Through engagement work in 2012/13 and 2013/14 with CCGs and GPs, a number of key insights were gained as to what is important from a primary care perspective and as clinical commissioners. These insights are summarised in Table 1 below. Many reinforce the recommendations made in the *Model of Care* and others, for example the importance of understanding co-morbidities and specific areas around communication, provide new insights that will need to be reflected in the refreshed strategy.

Table 1: CCG priorities as recorded at the 2012/13 engagement events

Themes	1. Early detection and diagnosis	2. Pathways and location of care delivery	3. Co-morbidities and management of cancer as a long-term condition	4. Improving communications	5. Data to support decision-making
Priorities	Improved screening	Changing profile of follow-ups	Integration of care	Regularity of communications	Performance data
	Public awareness	Care closer to home / in home	Role of primary care	Content of communications	Cost data
	GP to first diagnostic	Early discharge and enhanced recovery after surgery	Empower patients to self-care	Standardisation and use of templates	
	Awareness and appropriate use of referral routes	Provision of services for survivorship		Patient communications regarding palliative care	
		Decision when to stop treatment			
		Joined up palliative care			

Clinicians, commissioners and providers have been involved throughout the development of the five year commissioning strategy. Each of the workstreams comprises a steering group that oversees the development of the five year strategies with clinicians, commissioners and providers represented on these groups.

Each workstream presented its five year strategy at an extended meeting of the Cancer Clinical Leadership advisory group in November 2013 for clinical feedback and input. Pathway chairs from both ICSs were asked to join this meeting to widen the cancer clinical representation and engagement.

The Pan London Cancer User Partnership consists of cancer patients and carers from across London which meets regularly to provide feedback as to the cancer programme. Each workstream, during development, has been taken to the Partnership meeting for input during the 2013/14.

A sub group of the Cancer Commissioning Board met regularly between September and December 2013 to oversee the development of the five year strategy and to

¹⁰ <http://www.england.nhs.uk/2013/07/11/call-to-action/>

ensure progress was made. Again clinicians, commissioners and both ICSs made up this steering group.

The Cancer Commissioning Board received the five year strategy at its December 2013 meeting and was supportive of the direction of travel.

C. Cancer Commissioning Strategy for London: 2014/15 – 2019/2020

This strategy has been developed by reviewing each of the key areas of work within the *Transforming cancer services for London* programme across London. It has been a collaborative development between clinicians directly associated with each area providing clinical expertise; CCG representatives through recent engagement work and the contributions of recognised GP cancer leads; representatives from the Integrated Cancer Systems linking into the clinical pathway groups; commissioners from Public Health England; and commissioners from NHS England. The key areas of focus are:

1. Early detection and awareness
2. Reducing variation in secondary care (including service consolidation)
3. Patient experience
4. Chemotherapy
5. Radiotherapy
6. Living with and beyond cancer
7. End of Life care

Patient experience is, of course, central to the development of all workstreams and interventions are assessed against their impact on patient experience. However, because of the continuing poor patient experience in London, it has been identified as a workstream in its own right to ensure an on-going focus.

Cancer screening is key to the early detection and awareness programme. The screening team, funded by Public Health England and hosted by NHS England, has been developing a strategy for screening. A summary of this strategy is included within this document.

Additionally because of the intrinsic role of prevention in reducing mortality from cancer, recommendations are set out below as to what needs to be done in this area. The section on prevention has been written in collaboration with public health consultants leading to the recommendations set out below.

The document will follow the patient pathway from prevention, early diagnosis and awareness including screening to end of life care.

1. Preventing Londoners from developing cancers amenable to changes in lifestyle

Recommendations for commissioners:

Preventing cancer is the responsibility of each local health economy by helping people through specific programmes and multi-agency partnerships on reducing tobacco use, healthy eating, exercise, diet, alcohol harm reduction and especially smoking cessation, with particular focus on vulnerable groups.

It is recommended that CCG commissioners:

- Commission well-evidenced primary prevention programmes focussed on the key risk factors linked to London's biggest diseases.

There is evidence that there are a number of preventable or modifiable behaviours that may reduce an individual's risk of getting cancer. It is estimated that 43per cent cancers are attributed to lifestyle and environmental factors¹¹ meaning there is great potential to stop Londoners from developing cancer in the first place, delivering better patient experience and savings for the NHS.

The *British Journal of Cancer* review¹² looked at the numbers of cancers attributable to fourteen lifestyle and environmental factors in the UK in 2010. These factors include tobacco, alcohol, diet, being overweight and/ or obese, and levels of physical exercise. It is believed that more than 100,000 cancers – equivalent to one third of all those diagnosed in the UK each year – are caused by smoking, unhealthy diets, alcohol and excess weight.

Smoking is by far the most important risk factor for cancer responsible for 19.4per cent of all new cancer cases in 2010 equating pretty much to one in five cancers. 90per cent of lung cancers are associated with cancer¹³. The most significant action that could be taken in London to prevent cancer is to help smokers to stop and to prevent young people from starting smoking in the first place.

There are a number of local and pan-London activities that would support this ambition, for instance:

- Securing continued investment in evidence based stop smoking services and ensuring that these are promoted widely to *all* smokers, but particularly those in priority groups e.g. pregnant women, people with long term conditions.
- Ensuring all local health care professionals/practitioners are trained in delivering Very Brief Advice¹⁴ on smoking and know where to refer or signpost people to if they are interested in taking action to stop or reduce their smoking.

¹¹ The Fraction of Cancer Attributable to Lifestyle and Environmental Factors in the UK in 2010, BJC; Volume 105, Issue S2 (Si-S81) Published 6 December 2011, Dr D Max Parkin; with Lucy Boyd, Professor Sarah C Darby, David Mesher, Professor Peter Sasieni and Dr Lesley C Walker

¹² The Fraction of Cancer Attributable to Lifestyle and Environmental Factors in the UK in 2010, BJC; Volume 105, Issue S2 (Si-S81) Published 6 December 2011, Dr D Max Parkin; with Lucy Boyd, Professor Sarah C Darby, David Mesher, Professor Peter Sasieni and Dr Lesley C Walker

¹³ <http://www.cancerresearchuk.org/cancer-info/cancerstats/types/lung/riskfactors/lung-cancer-risk-factors>

¹⁴ http://www.ncsct.co.uk/publication_very-brief-advice.php

- Ensuring all secondary care providers follow recent NICE guidance¹⁵ in relation to the identification and referral of smokers, cessation and access to stop smoking medications. This also includes ensuring that all health care facilities (buildings and grounds) are smoke-free.
- Ensuring that individuals who are presenting with cancer symptoms and those who receive a cancer diagnosis are asked about smoking behaviours, informed of the help available to help them to stop and provided with the necessary support.

Next in importance are reductions in obesity in women and in heavy alcohol consumption particularly in men, and certain other dietary changes – including increasing consumption of fruit and vegetables and fibre, and reducing high consumption of meat and salt. Each of these four main strategies for cancer control would also substantially reduce the burden of other non-communicable diseases, particularly cardiovascular, diabetic, renal and hepatic disease.

High exposure to ultraviolet (UV) light can cause malignant melanoma in people with all skin types but people with fair and/or freckly skins are at higher risk. UV exposure includes strong sunlight and sun beds. Protecting the skin from strong UV light through the use of appropriate sunscreens or sun avoidance reduces the chances of getting malignant melanoma.

Prevention offers the most cost effective long term strategy for the control of cancer and earlier detection will improve prognosis.

Primary care has the potential and opportunity to coordinate care for better population health and wellbeing outcomes. As the commissioner of Primary Care, NHS England (London region) aims to provide an easily accessible route to care for individuals that is orientated toward self-reliance and self-determination with an emphasis on health promotion and illness prevention. It is currently working on a longer term transformation of primary care programme in order to ensure that primary care is proactive in empowering individuals to improve health literacy and creates environments in which individuals, families and communities know and can lead healthy lives.

Commissioning for prevention is one potentially transformative change that CCGs can make, together with Health and Wellbeing Boards and their other local partners. Reallocating resources to fund priority prevention programmes has the potential to support the prevention of a number of diseases including 43per cent of all cancer cases. To support this CCGs, local government, schools, providers, employers and others will need to work together to optimise the full range of resources there are available.

Implemented systematically, the evidence suggests prevention programmes can be important enablers for reducing acute activity and capacity over the medium term but currently only about 4 per cent of the total NHS budget is spent on prevention¹⁶.

¹⁵ <http://guidance.nice.org.uk/PH48/>

¹⁶ <http://www.england.nhs.uk/wp-content/uploads/2013/11/call-to-action-com-prev.pdf>

2. Cancer screening

Recommendations for commissioners in years one and two:

It is recommended that NHS England Screening commissioners:

- Work closely with Local Authority Public Health teams to ensure screening is a priority in Joint Strategic Needs Assessments and Health and Wellbeing strategies.
- Review contractual levers to incentivise coverage and uptake with screening providers.
- Support the rollout of BowelScope programme¹⁷.
- Commission the age extension for bowel screening.

It is recommended that NHS England Primary Care Commissioners:

- Develop education programmes in partnership with CCGs and the NHS England/Public Health England Screening team.
- Review the contractual levers to encourage uptake and coverage through primary care.

It is recommended that CCG commissioners and individual practices:

- Work with NHS England screening commissioners to facilitate the pathway from screening to treatment and achieve the 62 day pathway.
- Include screening in their educational activities for primary care.
- Nominate screening leads to champion and facilitate messaging.
- Work with local community groups (facilitated through links with local authority public health teams) to deliver messages about screening.

It is recommended that Local Authority commissioners:

- Work with other commissioners to improve public knowledge and understanding of screening programmes.
- Continue to commission cervical sample taking through community based family planning facilities.

London has the lowest coverage and uptake for cancer screening in England with large variation in take up between boroughs and inequalities between socio-economic and ethnic groups. There is evidence of poor public awareness and understanding of screening programmes in some groups across London¹⁸. Patient experience is also not systematically measured across all screening services.

New cancer screening programmes such as BowelScope for 55 years olds are being introduced across London offering new opportunities to prevent and diagnose cancers earlier.

To maximise the impact of new and existing programmes, it is vital uptake is optimised so that more people are diagnosed at an early stage or prevented from developing cancer through the identification of pre-cancerous conditions. Over the

¹⁷ (Bowel Scope is a new screening programme inviting people around their 55th birthday for a Flexible Sigmoidoscopy examination of the lower bowel)

¹⁸ Cancer Awareness Measures undertaken across London

course of this five year strategy the aim for cancer screening must be to ensure all Londoners have a good understanding of the benefits of screening and are thus able to make an informed choice about participating in screening.

Commissioners will need to commission high quality, patient focussed screening programmes demonstrating that they meet or exceed national standards and targets across all screening programmes and communities in London.

The cancer screening programme for London will:

- increase public awareness and engagement with cancer screening programmes across all communities;
- increase engagement of primary care and improve reliability of data;
- improve quality, capacity and patient experience of provider services to optimise coverage and uptake; and,
- facilitate high quality research to further inform strategies to improve coverage and uptake in London.

3. Early diagnosis and awareness

Recommendations for commissioners in years one and two

It is recommended that Public Health England commissioners:

- Continue investment in national *Be Clear on Cancer* campaigns which have shown to be effective in increasing referral rates.
- Explore contractual levers with dentistry and pharmacy that can be used to increase cancer awareness messaging and sign posting.

It is recommended that Primary Care commissioners:

- Mandate that two of the annual six pharmacy marketing campaigns are used for cancer awareness.

It is recommended that Public Health commissioners from Local Authorities and CCG commissioners:

- Commission locally-developed awareness campaigns to improve earlier detection of cancer, for example the *Get to know Cancer* pop up shop and cancer activist programmes.

It is recommended that CCG commissioners:

- Continue to invest in GP cancer leads that provide local leadership and co-ordination for early detection activities.
- Backfill GP sessions to enable GPs to attend training on using the cancer decision support tool.
- Commission along the best practice guidelines developed for the early detection of bowel, lung, ovarian and, when ready, vague abdominal symptoms and blood in urine.
- Commission additional endoscopy capacity for lower gastrointestinal cancers and to only commission from JAG accredited providers.

For many cancers, the earlier a cancer is diagnosed and treated, the greater the prospect of survival and improved quality of life. Achieving earlier diagnosis has the greatest potential for improving outcomes and survival for cancer patients in London. The implications for increasing earlier detection include increasing the volumes of patients referred for diagnostics.

The *case for change* notes that raising survival rates in England to match the best in Europe could save approximately 1000 lives per year in London and indeed this may be a low estimate. Recent modelling undertaken by Deloitte Monitor identified an additional 1470 patients could be diagnosed at a time when their cancer outcome could be improved.

Across London, 25per cent - 30per cent cancer diagnoses will occur in A&E where the potential for a successful outcome is much lower. A percentage of these will enter A&E as a result of direct referral from the GP to enable fastest access for the patient into secondary care. Acute Oncology Services, as detailed in section four, will enable both a better patient experience and outcomes for these patients.

For early detection and awareness, the refreshed strategy seeks to tackle each element of the pathway that can lead to a delay in diagnosis. From public delay in seeking medical advice due to fear, worry or a lack of knowledge of symptoms, to GP delay that stops prompt and appropriate referrals, to system delay that slows the time taken for a cancer diagnosis to be reached. Given the significant inequalities that exist across London, driven by factors including deprivation, ethnicity, single living households, age, it is also recommended that locally driven specific interventions target local inequalities.

The strategy prioritises the most common cancers in London where the potential for impact is greatest¹⁹:

- Bowel
- Lung
- Breast.

It also prioritises those where national estimates show large numbers of lives could be saved through earlier diagnosis:

- Ovarian
- Oesophago-gastric.

Melanoma or skin cancer is also prioritised because of the growing incidence and mortality rates²⁰. Although one of the most common cancers in men, prostate cancer is not prioritised here because of the lack of reliability of the current diagnostic for prostate cancer, the PSA test, and as London's survival rates are comparable to other parts of the country.

1. Public delay

Fear at what the doctor might find, worry about wasting the GP's time, lack of knowledge about specific cancer signs and symptoms and inability to make a GP appointment at a suitable time can all contribute to a public delay in getting medical help. A series of initiatives are proposed to tackle this.

Awareness campaigns of common signs and symptoms through further roll out and promotion of the national *Be Clear on Cancer* campaign is one approach to raising the public's understanding of signs and symptoms; one key priority area is raising awareness of breast cancer symptoms in women aged 70 and over as well as increasing the voluntary uptake of the breast cancer screening programme in this older population.

Additionally there is a need for local specific campaigns that target areas of inequalities and high cancer incidence. The *Get to know cancer* campaign utilises empty retail space on busy shopping streets to deliver a pop up shop staffed by cancer nurses and supported by volunteer Cancer Activists who are trained to talk about common cancer signs and symptoms. Evaluated by Kings College London,

¹⁹ Abdel-Rahman et al, BJC Supplement December 2009

²⁰ Cancer Research UK:

<http://www.cancerresearchuk.org/cancerinfo/cancerstats/types/skin/incidence/#trends>

the shops encourage people to talk about cancer in a non-clinical environment conveniently located in the community²¹. By profiling the fact that cancer survival rates have more than doubled over the last forty years and that earlier diagnosis can increase the chances of successful treatment, the *Get to know cancer* campaign works to target the fear and fatalism about cancer that can stop the public visiting the GP when they first notice something wrong.

Many healthcare providers will routinely come into contact with the public and those at higher risk of cancer providing an ideal opportunity to both educate the public about cancer signs and symptoms and/ or sign post those at risk to GP or other suitable services. From year one of the strategy, all dentists will have cancer checks written into their contracts as standard. Additionally pharmacies are required to promote 6 health marketing campaigns per year in stores: ensuring a percentage of these are cancer related provides an ideal opportunity to promote messaging. Building on these already established healthcare touch points is an obvious way to deliver additional, life-saving, cancer information.

The *Be Clear on Cancer* campaigns are nationally funded by Public Health England and occur three times per year. They are tested on the public before launch in order to ensure positive patient experience. These campaigns are therefore ready to implement and the recent lung cancer campaign has shown to increase two week referral rates²².

In addition to health care, there are also numerous touch points that individuals regularly come into contact with from adult and social care service managers in local authorities, to hairdressers, beauticians and taxi drivers. Again, exploring how London can use these already well-established touch points offers innovative ways of disseminating information.

Case study – *Get to know cancer* activist programme

The *Get to know Cancer* activist programme trains local volunteers to be able to talk about cancer signs and symptoms and the importance of early detection.

In December 2013 the programme trained twenty service managers from Redbridge Council who work with elderly people and those with learning difficulties. As age is a risk factor in developing cancer and evidence shows that people with learning difficulties are less likely to take up cancer screening, this is an ideal opportunity to disseminate messages through social care workers already coming into contact with members of the community.

2. GP delay

Interventions tackling GP delay will improve the patient experience since patients will be referred more promptly, access diagnostics quickly and, where referred onto a diagnosis pathway, should reach that diagnosis more quickly. In the same way,

²¹ Evaluation of the 'Get To Know Cancer' pop up shop initiative; 2013, Kings College London

²² Cancer Research UK; *Be Clear on Cancer* evaluation

patient outcomes should improve as this will lead to diagnoses made at an earlier stage of the cancer.

Supporting GPs to be able to spot signs and symptoms of cancer and refer appropriately and in a timely manner is key to reducing delays at the GP surgery. There are a number of tools that can be used to support GPs refer appropriately and promptly. Local GP leadership is vital to making sure these tools are received and embedded.

This strategy recommends rolling out the existing practice profile programme that highlights nationally produced data on referral patterns and cancer incidence within a GP practice offering a useful learning and reflection tool for GPs. Evaluation has demonstrated a 3per cent increase in two week wait referrals in practices that had some form of intervention, including practice profile programmes in place²³.

The Cancer Decision Support tool works with existing IT systems to log combinations of symptoms that patients present with and to flag to the GP where cancer is a possibility. This tool has been developed by Macmillan and early evaluation shows a positive result²⁴. Rolling this tool out to all practices across London would be an excellent support tool. The costs associated with roll-out are the costs of backfilling GP sessions in order to release them to receive training on the tool as well as the likely additional two week wait referrals.

In 2012/13, three best practice commissioning pathways for the earlier detection of lung, ovarian and colorectal cancers were developed in order to support GPs to refer and to increase the speed at which a patient receives a diagnosis. CCGs have been asked to commission along these pathways. It is proposed two further pathways are developed to tackle those patients who present with “vague abdominal” symptoms that could relate to a number of different cancers. The current pathway sees patients referred along one pathway, e.g. colorectal, but if colorectal cancer is not found, the patient is referred back to the GP who needs to make a second assessment as to where the patient should be referred.

A second pathway is also recommended which would improve referrals for patients presenting with blood in urine linked to kidney and bladder cancers. A pathway that supports patients to reach a diagnosis quickly no matter where their cancer originates will improve patient experience and outcomes.

Direct access to diagnostics was a commitment made in the national strategy, *Improving outcomes: A strategy for cancer*²⁵, for:

- non obstetric ultrasound;
- chest X-ray;
- flexible-sigmoidoscopy; and,
- Brain Magnetic Resonance Imaging.

²³ <http://www.rcgp.org.uk/clinical/clinical-resources/~media/Files/CIRC/Cancer/Cancer%20Cascade%20Programme/Cascade-London-2013-Greg-Rubin.ashx>

²⁴ Interim evaluation to be published in February 2014

²⁵ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213785/dh_123394.pdf

Progress has been made in London in ensuring all GPs have direct access to these diagnostics and this is included within contracts across London.

It may be also be that other diagnostics are suitable for direct access in Primary Care, including CT scan for vague abdominal symptoms, and this strategy proposes developing clinical guidelines in year one as to when direct access for CT scan is appropriate. Molecular biomarkers are increasingly being researched meaning in future there may be an increase in the use of blood-based diagnostics which can be carried out in Primary Care settings. For commissioners, in the future, there may be further opportunities to commission diagnostics outside of the secondary care setting.

3. System delay

Insufficient capacity in secondary care to meet rising referral demand can also play a role in delaying the time it takes to get a diagnosis.

England's rates of endoscopy for lower gastrointestinal cancers per 100,000 population lag behind comparable countries. Endoscopy services themselves, also vary in quality with many not JAG accredited²⁶, the marker of a quality service, and some patients experiencing six plus and thirteen plus week waits for endoscopy. The impact of this is felt in England's poorer cancer outcomes for bowel cancer than in comparable countries. The introduction of Bowel scope will also increase demand on endoscopy for lower gastrointestinal cancers. Consequently developing and implementing a strategy for the endoscopy (colonoscopy and flexi sigmoidoscopy) is recommended as a priority for London.

This will improve patient experience by reducing waiting times and ensuring every patient receives a quality assured endoscopy and will improve patient outcomes by accelerating diagnosis. Clinically-led recommendations have already been developed meaning this initiative is ready for commissioners to implement in year one of the strategy.

It is also recommended that an endoscopy strategy for upper gastrointestinal cancers is developed and implemented due to the poor survival rates of these cancers and due to the lack of standards in endoscopy for upper gastrointestinal cancers. This work is in an early stage and therefore will not be ready for commissioners until year two of the strategy.

4. Targeted initiatives for high risk populations

Across London, wide variations in cancer outcomes exist and inequalities persist in communities living side by side driven by factors including ethnicity, gender and socio-economic status. If London is to truly reduce variation and bring London's outcomes up to match best in world, it is recommended that targeted interventions are commissioned to reach high risk populations.

²⁶ <http://www.thejag.org.uk/>

The Cancer Awareness Measures delivered in London found that many people worried about wasting their GP's time and/ or could not make an appointment. Although there is great debate across London as to the appropriateness of direct access to secondary care, one option to overcome this could be the commissioning of rapid access clinics for high risk populations which would enable Londoners direct access to diagnostics. Further work needs to be done to identify whether this would be a suitable approach and if it would have impact.

Smoking rates in some parts of London reach between 40 per cent and 60 per cent²⁷ depending on the local community. Lung cancer rates in women are also rising. Low dose CT scanning for populations at high risk of lung cancer is one option to identify early lung cancers prior to the development of lung cancer symptoms. This would have a positive impact on patient outcomes since resection for lung is dependent on the tumour being at an early stage. London Cancer is exploring whether it can pilot a CT screening programme; the National Screening Programme has also applied for funding to run a CT screening pilot for high risk populations.

A final recommendation is for Hepatocellular Carcinoma Cancer (HCC) surveillance. Risk factors for HCC including chronic viral hepatitis and alcoholic liver disease; most of these risk factors lead to the formation and progression of cirrhosis, which is present in 80-90per cent of patients with HCC²⁸. Regular surveillance of at risk patients is aimed to detect HCC at an early enough stage where curative treatment is possible.

Using traditional healthcare touch points in South West London to target health inequalities: the role of Pharmacy

43 pharmacies in areas of deprivation in Croydon, Wandsworth, Sutton and Merton participated in a direct access to chest x-ray pilot for customers at risk of lung cancer.

Following training, counter staff were asked to offer a private consultation with the pharmacist to any customer aged over 50 with a smoking history, buying cough medicines, nicotine replacement therapy, collecting a prescription for antibiotics for a respiratory complaint or seeking advice about a respiratory complaint. Where patients met tailored NICE referral guidance, the pharmacist could refer the customer directly to a chest clinic.

From 55 appropriate referrals made to the Chest clinic during the 6 month pilot, 47 customers accepted. Whilst no lung cancer was diagnosed, other significant diagnoses were made in 31 patients (66%) including 14 cases (30%) of moderate/severe COPD/emphysema. A key feature of the pilot was health promotion and increasing lung cancer awareness. All current smokers were offered a referral to a smoking cessation service.

The pilot demonstrated very positive and promising results with regard to acceptability in both primary care and secondary care of direct access to a chest clinic. It also received positive feedback from pharmacy customers who reported that it was far easier to engage with pharmacists on the subject of lung cancer than their GPs and were impressed with the speed of the referral process.

²⁷ As noted in London borough's JSNAs

²⁸ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3036965/>

Assessment of the early detection and awareness interventions

Early detection and awareness				
Intervention	Patient outcomes	Patient experience	Readiness to deliver	Notes
Rapid access clinics for high risk populations				
CT scan for high risk population of lung cancer				
HCC surveillance				
Breast cancer – over 70s				
Raise population awareness of specific signs and symptoms				
Utilising healthcare touch points				Pilots in year one
Utilising non healthcare touch points				Pilots in year two
Roll out of the Cancer Decision Support tool				
Managing procedures in community settings: skin lesion excision				
Greater access for GPs to CT scan for vague abdominal symptoms				
Development of best practice pathways				
Continual learning – Primary Care				
Practice profiles				
Endoscopy for Lower GI				
Endoscopy for Upper GI				

Guide

For patient outcomes and experience:

- Green indicates high impact
- Amber indicates medium impact
- Red indicates low impact.

For readiness for implementation by commissioners:

- Green indicates readiness in year one
- Amber indicates readiness in year two
- Red indicates readiness in years three – five of the strategy.

4. Reducing variation and service consolidation

Recommendations for commissioners in years one and two:

IOG guidance and best practice pathways

It is recommended that CCG commissioners:

- Commission along these best practice pathways in order to reduce variation and improve overall quality
- Ensure all providers to reach IOG compliance through effective performance management of contracts.

Breast cancer:

It is recommended CCG commissioners:

- Use contractual levers to improve performance along the 23-hour pathway.
- Request trust action plans for implementing the 23 hour pathway

Lung cancer

It is recommended CCG commissioners and Primary Care commissioners:

- Commission along the best practice early detection pathway for lung cancer to ensure greater numbers of lung cancers are diagnosed at a stage when they are suitable for a resection.

It is recommended CCG commissioners:

- Request Trust action plans as to how they will increase resection rates
- In North Central and North East London are recommended to identify contractual levers to increase use of laparoscopic techniques.

Colorectal cancer

It is recommended CCG commissioners:

- Request Trust action plans to improve laparoscopic surgery rates
- Look at contractual levers to drive up usage of laparoscopic surgery
- Commission along the best practice guidelines to reduce variation in colorectal resections, improving patient experience, outcomes and reducing cost.

Acute Oncology Services (AOS)

It is recommended CCG commissioners:

- Ensure compliance of provider organisations with peer review metrics for AOS in order to increase quality of services.

Diagnostics

It is recommended CCG commissioners:

- Commission along the RCR and RCGP recommendations to increase the reporting time for diagnostic tests.

Reconfiguration of services for rarer cancers

It is recommended CCG commissioners:

- Support the development of plans on the proposed reconfigurations to improve services in North Central and North East London

As the *Case for Change* demonstrated, London experiences significant variation in the incidence and mortality rates of cancer patients across London with inequalities in access and outcomes.

Both Integrated Cancer Systems (ICSs) have worked together to develop a plan for reducing variation and service consolidation for London. Both London Cancer Alliance and London Cancer have provided assessments of where Trusts in their patch were performing against recommendations which led to the examples for recommended interventions. There is consensus from both ICSs on the recommended areas of intervention.

Best practice guidelines are being developed by both ICSs and both will have published these by the end of March 2014. Each pathway aims to ensure Trusts are compliant with national IOG and, whilst more work is needed to fully understand what needs to be done to achieve this, commissioners can support with their implementation.

The most common cancers in London have been prioritised in the first instance because of the potential to improve patient outcomes and patient experience for larger numbers of Londoners. Additionally, London Cancer has focussed primarily on rarer cancers such as brain and CNS, urology, head and neck and specialist haematology due to significant gaps in meeting existing NICE IOG compliance. London Cancer's clinicians have made recommendations to commissioners for how services could be changes in order to improve outcomes which are now being considered.

For other areas, work is continuing to develop the thinking for less common and rarer cancers and will make recommendations to commissioners at a later stage.

Key recommendations from the common cancers where work has been prioritised are summarised:

1. Breast cancer

In 2012, there were 4876 diagnoses of breast cancer in London²⁹ and breast cancer is the most common cancer in the UK. London Cancer Alliance has already published clinical guidelines on breast cancer.

23-hour mastectomy

Experiences vary for women in terms of the length of stay in hospital they will have for a mastectomy. The standard approach for surgery for breast cancer should follow a 23-hour pathway unless there are clinical reasons to justify exceptions. However there is variation in the percentage of women who will receive the 23-hour pathway ranging from 44 per cent to 96.4 per cent across London's providers³⁰.

²⁹ ENCORE; Cancer Analysis System, 2012 figures

³⁰ NCIN – cancer commissioning toolkit – National breast service profile

By reducing this variation, 500 extra women could receive the 23-hour pathway and associated reduction in bed days and improved patient experience. Whilst this will not drive a cost saving for commissioners through reduced length of stay, this initiative will improve patient outcomes, patient experience and improve provider efficiency.

Timely access to breast reconstruction

Post mastectomy, best practice requires all women to have the opportunity to discuss their breast reconstruction options and have immediate breast reconstruction where appropriate. Provider networks should be set up to facilitate every patient being offered reconstruction in a specialist centre. Again there is evidence of wide variation in the numbers of women being offered immediate reconstruction to enable every patient to have the choice.

This initiative is prioritised for the improved patient experience and should be cost neutral to commissioners since activity is only brought forward – by women having breast reconstruction sooner – and is not expected to increase.

Management of metastatic disease

There is variation in how patients are treated when there is a suspicion of metastatic breast cancer. Patients with recurrent or metastatic breast cancer should receive multidisciplinary care and the support of a CNS, as outlined in the NICE breast quality standard but there is little evidence to the current baseline of practice. Bringing every trust up to the optimal can only serve to improve both patient outcomes and experience as metastatic diagnosis is reached quickly and the patient reviewed by the appropriate clinical team.

Year one of this work is therefore to understand current practice across the ICSs with a view to in year two being able to implement standardisation.

2. Lung cancer

3724 Londoners were diagnosed with lung cancer in 2012³¹. Alarming lung cancer rates are increasing in women in many London boroughs³². The National Lung Cancer Audits have identified the variation in lung resection rates across England and this is in addition to the already low base number when compared to European counterparts.

Increasing lung resection rates

Evidence suggests that higher lung resection rates can increase lung cancer survival and that lung cancer survival could increase if a larger proportion of patients underwent surgical resection³³. The variation in resection rates for lung cancer patients treated across London's provider organisations shows rates ranging from

³¹ ENCORE; Cancer Analysis System, 2012 figures

³² As noted in Joint Strategic Needs Assessments across London

³³ Riaz et al 2011

2.4per cent to 31per cent³⁴. Whether a resection occurs or not depends on both the stage of diagnosis and the input of thoracic surgeons at all lung MDTs, this initiative therefore links to the best practice commissioning pathway for the earlier detection of lung cancer which will be implemented in year one of this strategy.

London Cancer laparoscopic surgery for lung cancer

London Cancer has additionally prioritised laparoscopic surgery for lung cancer as a minimally invasive technique.

Lung cancer treatment in the over 70s

Evidence shows that the over 70s are less likely to receive active treatment for lung cancer³⁵. However there is currently little known about the rates of active treatment given across London. Work is required to understand both the treatment options offered to this cohort of patients and the factors that impact on treatment choices.

Therefore overall readiness is low for year one of the strategy, but generally greater emphasis on ensuring consistency of care for the elderly will be an important area in the period of this strategy. NB. It is likely this will apply to all recommendations.

3. Colorectal Cancer

3463 Londoners were diagnosed with colorectal cancer in 2012.³⁶ Between 1971 and 2008, incidence rates for colorectal cancer increased by 33per cent for men and 12per cent for women. In 2008, colorectal cancer accounted for 14per cent of all new cancer diagnoses in men (57 new cases per 100,000 population) and 12per cent in women in England (37 new cases per 100,000)³⁷.

Laparoscopic surgery

Laparoscopic colorectal surgery allows faster recovery from surgery for patients suitable for this technique, therefore reducing bed days and improving patient experience. If patients are deemed suitable for both laparoscopic surgery and open surgery, NICE recommends laparoscopic surgery is performed. Across London, the laparoscopic rate varies significantly across the provider organisations from 11per cent to 84per cent³⁸.

³⁴ Lung cancer resection rates for patients in 2012; LUCADA – 2013 report

³⁵ Age, comorbidity, treatment decision and prognosis in lung cancer; Oxford Journals 2008

³⁶ ENCORE; Cancer Analysis System, 2012 figures

³⁷ <http://www.ons.gov.uk/ons/rel/cancer-unit/bowel-cancer-in-england/2008/colorectal-cancer-in-england-2008.html>

³⁸ Laparoscopic resection rates – 2011/12; NBOCAP audit report 2013

Major resection for colorectal cancer

The length of stay and readmission for patients following major resection for colorectal cancer also varies across London. The average length of stay can range from seven to 13 days. Emergency readmission can range from 8per cent to 30per cent across the LCA. Implementing standardised guidelines will assist in reducing both length of stay and emergency readmission thereby improving patient outcomes, patient experience and reducing cost.

4. Improving access to services

Acute Oncology Services (AOS)

In addition the to the high percentage of patients first presenting in A&E with a previously unidentified cancer diagnosis, cancer patients also present with chemotherapy and radiotherapy complications as well as progressive disease symptoms. London Cancer Alliance has already published guidelines on AOS.

The *Model of Care* recommended all hospitals with emergency departments should establish an acute oncology service to ensure appropriate assessment of cancer patients presenting as an emergency. Whilst AOS services have been introduced there is variation in the provision. The national peer review process has identified that a significant number of acute trusts fail to meet the AOS metrics for peer review.

Evidence from Trusts which have implemented an AOS suggests that the largest reductions in length of stay between 8.5 and 11 days are found for patients with newly diagnosed cancer. Emergency admissions for patients with known cancer had reduced length of stay for patients of on average 3.7 days. Chelsea and Westminster for example has achieved 1695 bed saving days per annum plus an estimated annual saving of £476,631³⁹. Patient experience is a key benefit of acute oncology services enabling a swift transfer for the patient to a multi disciplinary team, expediting the time taken to reach a cancer diagnosis and supporting an avoidance of hospital admission in some cases.

Diagnostics

Reporting times for diagnostic imaging varies across London. In 2013, the RCR and RCGP published *Quality imaging services for Primary Care: a good practice guide*⁴⁰ which sets out minimum turnaround times for reports. To reduce delays in reaching a diagnosis, it is recommended all providers adopt the recommendations set out in the RCR and RCGP report.

³⁹ Chelsea and Westminster example of AOS: Acute Oncology Dr Thomas Newsom-Davis Consultant Medical Oncologist

⁴⁰ <http://www.rcgp.org.uk/revalidation-and-cpd/~media/Files/CfC/RCGP-Quality-imaging-services-for-Primary-Care.ashx>

Specialist diagnostics

With the advancement of stratified medicines in treating cancers, comes the need for more specialist diagnostics that identify biomarkers. Increasingly it is likely such molecular testing will become the norm for diagnosis, treatment and stratification of cancer patients. Molecular tests are currently predominantly ordered via oncologists. There is further work to do in London to rationalise services so that expertise is concentrated to ensure new tests are introduced in a timely and equitable way.

Currently further understanding is required as to how molecular diagnostics are commissioned.

5. Rarer cancers and consolidation of services

The LCA is currently developing a baseline of compliance of provider organisations against the NHS England Service Specifications to undertake gaps in service provision. The findings of this will determine whether there is a case for consolidation of specialist services. Currently there are no plans to consolidate services in the LCA area.

London Cancer has recommended to commissioners that outcomes could be improved by consolidating services for rarer cancers: the current arrangement of some specialised services in North Central and North East London does not deliver the best outcomes for patients. Central to this is the fact that patients with some rarer cancers are being treated in hospitals that see a relatively small number of people with the same rare cancer meaning there is a lack of expertise in the delivery of care, long waiting times for specialist care and unequal access to out of hours specialist care. Consequently outcomes for some patients are not as good as they could or should be.

The *Case for change*⁴¹ published in October 2013 sets out a compelling vision for the creation of world class specialist centres for cancer in North Central and North East London. The specialist centres would work with the other hospitals in the area and out-of-hospital services to provide a comprehensive network of care spanning from prevention and early diagnosis to treatment of disease, and ensuring that the majority of care is provided as close to home as possible. Consolidating services in high volume, specialist centres will result in improvements in clinical care and patient experience. Clinicians have recommended consolidating services for brain cancer, urological cancer, head and neck cancer, acute myeloid leukaemia and haematopoietic stem cell transplantation and oesophago-gastric cancer.

Commissioners are considering these clinical recommendations and other elements such as patient experience, research, education and training. Working with patients, the public and their representatives, commissioners will identify viable options that will address this case for change and aim to come to decisions on change in summer 2014.

⁴¹ <http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/10/ldn-tec-pack.pdf>

There is a wealth of other interventions being worked on by the two Integrated Cancer Systems. These include improvement of referral pathways, enhanced recovery, reduction in unplanned hospital admissions for end of life care and increased provision of specialist intensive treatment unit beds. Whilst these are all important for patient outcomes and patient experience, further work is needed to understand the impact for commissioners.

Assessment of the reducing variation and service consolidation interventions

Reducing Variation and Service Consolidation London Cancer Alliance				
Intervention	Patient outcomes	Patient experience	Readiness to deliver	Notes
Breast - 23 mastectomy				
Breast - immediate breast reconstruction				
Breast - metastatic management				Modelling work is underway
Breast – timely/ equitable access				
Lung - resection rates				
Lung - treatment for over 70s				
Colorectal - laparoscopic surgery				
Colorectal - major resection				
Acute oncology services				
Diagnostics - imaging				
Complex molecular diagnostics				
Rarer cancers - Consolidation of services				

Reducing Variation and Service Consolidation London Cancer				
Intervention	Patient outcomes	Patient experience	Readiness to deliver	Notes
Breast - 23 mastectomy	Green	Green	Green	
Breast - immediate breast reconstruction	Green	Green	Green	
Breast - metastatic management	Green	Green	Amber	
Breast – timely/ equitable access	Green	Green	Amber	
Lung - resection rates	Green	Green	Amber	
Lung – laparoscopic surgery	Green	Green	Amber	
Lung - treatment for over 70s	Green	Green	Amber	
Colorectal - laparoscopic surgery	Green	Green	Green	
Colorectal - major resection	Green	Green	Green	
Acute oncology services	Green	Green	Green	
Diagnostics - imaging	Green	Green	Green	
Complex molecular diagnostics	Amber	Amber	Red	
Rarer cancers - Consolidation of services	Green	Amber	Green	

Guide

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5. Chemotherapy

The *Model of Care* made key recommendations relating to chemotherapy:

1. Inpatient delivery of Systemic Anti-Cancer Therapy (SACT) should be minimised and satellite services set up linked to a central unit in the provider network to provide treatment closer to home where clinically appropriate
2. Community settings should be considered by provider networks to provide high quality care closer to home.

There is a strong drive for commissioners to look at moving chemotherapy services closer to the patient's home especially as increasing incidence of cancer and advances in drug development that will place increasing strain on providers. However, whilst there is anecdotal evidence that patients would prefer to have their care delivered closer to home, there is currently a lack of robust evidence to support this assumption

The chemotherapy strategy aims to build the evidence base for patient and carer preferences in the delivery of care closer to home. This should ensure that patient experience is central to the options proposed to deliver chemotherapy closer to home.

A number of oral chemotherapy drugs have been introduced in recent years which may be suitable for administration at home. As VAT is not incurred on oral medicines administered at home, this presents a savings opportunity for commissioners but further work is needed to map current and future practice in this area.

Other areas of drug innovation include the growing numbers of subcutaneous formulations for medicines previously administered intravenously. Subcutaneous administration reduces the length of stay a patient needs to spend in hospital thereby improving patient experience and reducing costs. NHS England commissioners are currently modelling the impact of introducing subcutaneous formulations across all London providers to understand both the cost impact and to develop a consistent approach for its introduction.

Assessment of the chemotherapy interventions

Chemotherapy				
Intervention	Patient outcomes	Patient experience	Readiness to deliver	Notes
Chemotherapy closer to home				
Home delivery of oral chemotherapy				
Implementing use of subcutaneous formulation				Modelling work is underway

Guide

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6. Radiotherapy

Recommendations for commissioners:

It is recommended NHS England commissioners:

- Explore the potential for commissioning the evaluation of comparative treatment delivery to understand the impact of Stereotactic Ablative radiotherapy (SABR)
- Model the potential impact of introducing hypofractionation regimens as standard.

Radiotherapy is a key component in the treatment of cancer and demand has and is steadily increasing with rising cancer incidence and complexity of treatments being delivered. It is delivered at eight NHS Trusts in London as well as services available to Londoners at Mount Vernon.

The *Model of Care* outlined two recommendations for radiotherapy, both of which have since been addressed:

- Agreement should be reached across London on referrals for radiotherapy treatments, fractionation regimens and maximum waiting times.
- Centralised commissioning of radiotherapy should be considered to ensure that patient flows are managed more efficiently across London and to maintain high safety and quality standards.

Radiotherapy techniques, however, are continuously changing and improving. To benefit London's population, it is important new techniques rapidly enter regular practice. Newer techniques offer the added benefit of causing fewer long term side effects enabling patients to return to more normal life as soon as possible. The strategy for radiotherapy therefore focuses on how to introduce advanced techniques into routine commissioning as quickly as possible.

Stereotactic Ablative radiotherapy (SABR) is defined as fractionated stereo-tactic/ high precision radiation of a limited volume. It has been shown in early trials to be an effective treatment for some cancers⁴². SABR capacity in London has increased rapidly but without an evidence base or formal approval from commissioners. Year one of this strategy therefore proposed to lead a project to determine the potential for commissioning the evaluation of comparative treatment deliver to build an evidence base for the use of SABR.

Hypofractionation is another promising form of radiotherapy that offers to give larger doses of radiotherapy in fewer overall fractionations. Clinical trials are currently exploring the usage and effectiveness of hypofractionation but two trials in breast and prostate cancer have shown early promising results⁴³.

⁴² National Cancer Action Team, 2011; <http://www.england.nhs.uk/wpcontent/uploads/2013/08/b01-p-a.pdf>

⁴³ Clinical Study of Hypofractionation in Prostate Cancer (CHHiP): http://www.icr.ac.uk/research/team_leaders/Dearnaley_David/Dearnaley_David_RI/Hypofractionation_Prostate_Cancer/18365.shtml and UK Standardisation of Breast Radiotherapy (START) trials of radiotherapy

Assessment of the radiotherapy interventions

Radiotherapy				
Intervention	Patient outcomes	Patient experience	Readiness to deliver	Notes
Stereotactic Ablative radiotherapy				
Hypofraction				

Guide

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- Amber indicates medium impact
- Red indicates low impact.

For readiness for implementation by commissioners:

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- Amber indicates readiness in year two
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hypofractionation for treatment of early breast cancer:
[http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045\(13\)70386-3/abstract](http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(13)70386-3/abstract)

7. Patient experience

Recommendations for commissioners:

It is recommended CCG commissioners and NHS England commissioners:

-Specify the patient experience priority areas for quality indicators.

It is recommended CCG commissioners:

- Request action plans from Trusts as to how they are improving patient experience.

For travel costs, trusts currently reclaim patient transport costs from the CCG so there may be opportunities for CCGs to use contractual levers to improve this expenditure to raise patient satisfaction.

The national cancer patient experience survey for the last two years shows nine out of the ten worst trusts in England for patient experience as being in London. The *Model of Care* made several recommendations as to improving patient experience for Londoners including smooth transitions between different care settings from specialist centre to local hospital or Primary Care.

Building on the *Model of Care* priorities and extensive engagement with patient groups across London, a patient centred workshop to identify key themes for the five year strategy and robust discussion and challenge at the Pan London Cancer User Partnership, six key areas have been identified that need to be addressed in order to improve patient experience.

A number of options for improving each theme are put forward within the detailed strategy. Whilst not every area is something that is commissioned as such, it is central to driving up improvements in patient experience in London.

Travel and parking

Patients report struggling with the stress and costs of public transport and, where private transport is used, the costs of parking in London. Where hospitals do provide patient transport, journeys are often long as they need to make repeated stops for other patients and require patients to be ready two plus hours before their appointment compounding the anxiety and stress of treatment.

Systems and waiting times

38per cent of patients had to wait longer than 15 minutes for an appointment and 39per cent were not told how long they would have to wait⁴⁴. Long waiting times for appointments compound the impact of travel times and costs and can add to the stress and anxiety of appointments or undergoing treatment.

⁴⁴ 2011 Outpatients survey

Staffing levels

There is good evidence that positive staff experience has a positive impact on patient experience. London has poorer staff to patient ratios than other parts of the country, a greater turnover of staff and greater use of agency staff, all of which can unsettle team working as new staff adapt to new policies and processes. Evidence has shown that patients are more likely to have a positive experience if a cancer nurse specialist is in place and accessible to them. Variation in the numbers and experience of CNSs across London again leads to variation in experience.

Behavioural issues

It is important to remember that every member of staff a patient comes into contact with when they enter the NHS will impact their experience and not just the cancer specialists treating them. Issues around behaviour, communication and compassionate and respectful care are often mentioned in hospital complaints. Good communication between staff and patients is another recurring theme that needs to be improved to change patient experience for the better.

Transition points between settings of care

Transitioning between settings of care or between teams has been the subject of complaints in the NHS for many years, as patients get stuck or lost in symptom or simply have to repeat medical history and routine tests when they move to the new setting. Integration between settings of care will help to improve these transition points.

Primary Care

There is need for better support from Primary Care for patients during treatment as to their care. Patients also feel they need to have better confidence in their GP to help them post discharge. This links to the need for better communication between Primary and Secondary Care.

Assessment of the patient experience interventions

Patient Experience				
Intervention	Patient outcomes	Patient experience	Readiness to deliver	Notes
Travel and parking	Red	Green	Amber	
Systems and waiting times	Amber	Green	Amber	
Staffing levels	Amber	Green	Red	
Behavioural issues	Red	Green	Green	
Transitions between settings of care	Amber	Green	Amber	
Primary Care	Amber	Green	Amber	

Guide

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For readiness for implementation by commissioners:

- Green indicates readiness in year one
- Amber indicates readiness in year two
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8. Living with and beyond cancer

Recommendations for commissioners:

Elements of the Recovery Package (Holistic Needs Assessment, Care Plan, Treatment Summary and Health and Wellbeing Event) are commissioned by different commissioners – CCGs, NHS England (specialist commissioning and Primary Care contracting) and local authorities. Many elements are commissioned by NHS commissioners – e.g. stratified pathways - but local authorities have a role to play in health and wellbeing, due to their public health responsibilities and, as demonstrated, by the Islington case study.

It is recommended that CCG commissioners and NHS England commissioners:

- Continue the roll-out of the Recovery Package, expanding coverage and uptake, moving from Holistic Needs Assessment, Care Plan and Treatment Summary, to include all aspects of the Recovery Package.

It is recommended CCG commissioners:

- Commission stratified pathways, recognising their dependency on the availability of the Recovery Package
- Ensure that all MDTs have referral pathways in place for lymphoedema services, pelvic radiation disease and sexual dysfunction support and counselling.

It is recommended that CCGs, Public Health England and Primary Care commissioners:

- Consider how cancer support and follow-up can be integrated with the on-going management of other long term conditions.

There are more than 200,000 Londoners living with or beyond cancer and, using national assumptions, this figure is predicted to double by 2030. With improvements in early detection and rapid advances in treatment, we should expect even larger numbers of people living beyond cancer.

Supporting people recovering from a cancer episode, or living with recurrent episodes of cancer, is nowadays comparable to other long term conditions albeit with cancer-specific interventions still required. Additionally certain cancer treatments can increase the risk of long term conditions such as heart disease, osteoporosis or a second cancer, and can add to other acute and chronic conditions.

The *Model of Care* recommended that every patient receive a holistic assessment as to the care needed and the level of support required. Psychological support was also highlighted as an area of need. It was recommended that psychological staff should be embedded within clinical teams to ensure that all levels of psychological need are met appropriately. Equitable access to psychological support services should be explicitly commissioned and managed in the provider network.

The Department of Health, in partnership with Macmillan, published the National Cancer Survivorship Initiative: *Living with and beyond cancer: taking action to*

*improve outcomes*⁴⁵ in March 2013. This sets out a clear framework for supporting the increasing numbers of people living with and after cancer. To improve the care and support for the current 200,000 Londoners living with cancer, recommendations follow the framework set out in the 2013 document.

1. The Integrated Recovery Package

The integrated recovery package comprises:

- Holistic Needs Assessment
- Care plan
- Treatment summary
- Health and wellbeing event.

A key to good survivorship is creating a shared understanding between patient and healthcare professionals about what to expect during recovery and identifying any needs to be addressed. Delivery of Holistic Needs Assessments and care planning were included as cancer peer review measures in April 2011. These interventions can play an important role in establishing a baseline from which a patient's recovery can be planned and supported: they also support patients to take control of their own recovery and to promote positive lifestyle change.

Undertaking the HNA takes approximately one hour [nursing or other] time. It ensures each patient has appropriate information and a clear management plan following treatment. With plans in place, the need for unplanned follow up appointments and contact should be reduced thereby resulting in reduced cost over the long term.

The health and wellbeing event is an education and information event to enable people living with cancer and their families to take control and participate in their recovery, giving them necessary information and promoting positive lifestyle change.

The health and wellbeing event includes psychosocial support, a boost to the role of physical activity and to provide work and finance support, where appropriate. Current evidence supports the recommendation of exercise:

- a. During treatment to prevent decline in functional outcomes without increasing fatigue;
- b. After treatment to support effective recovery of physical function; and
- c. To reduce the risk of recurrence of cancer and mortality.

Lack of exercise is a risk factor for several major diseases, including coronary heart disease, stroke and diabetes. Thus, following diagnosis, physical activity can also assist in reducing the risk of developing other conditions.

⁴⁵ <https://www.gov.uk/government/publications/living-with-and-beyond-cancer-taking-action-to-improve-outcomes>

Case study – Islington cancer survivorship exercise programme

The Islington cancer survivorship exercise programme aims to improve the physical and psychological wellbeing of cancer survivors and promote secondary prevention. It offers a free 12-week tailored exercise programme to Islington residents who have had a cancer diagnosis within the last five years. A number of activities are available, including Nordic walking, Pilates and gym sessions, as well as motivational support. Since the pilot began in March 2012, 139 cancer survivors have been referred to the programme and 69per cent have completed the programme to date. Interim evaluation results show those who completed the programme have reported improvements in health and wellbeing based on outcome measures including fatigue, functional limitation and mental wellbeing. Additionally, participant satisfaction and knowledge of physical activity was very high and 90per cent of participants took out gym membership following the programme, indicating an intention to continue exercising. One participant said, ***“I think the programme is fabulous and has given me a ‘new lease of life’. I feel much stronger physically and more confident as I look and feel so much better. The programme has also lifted my spirit and morale. I see this as being an integral part of my life and wish to continue being active.”***

The service has now been commissioned for a further three years.

Over the first two years of the plan, it is expected that 60per cent patients will have a Holistic Needs Assessment and care plan completed and that 75per cent patients will have a treatment summary.

Within five years, it is expected 100per cent patients will have all elements of the Recovery Package offered to them. All patients, where relevant, will be offered and financial advice, physical activity and psychosocial support as routine.

It is expected the Integrated Recovery Package will deliver longer term savings since the package removes a number of outpatient follow up appointments and should support the reduction in recurrence of cancer and the onset of other illnesses linked to side effects of treatment.

2. Stratified pathways for the follow-up of cancer patients

The National Cancer Survivorship Initiative⁴⁶ recommends that, following initial treatment, all patients should be assessed for their risk of developing further disease or consequences of treatment, i.e. be risk-stratified. This risk stratification will identify those who can safely self-manage without the need to attend hospital-based follow up appointments.

NHS Improvement piloted risk-stratified pathways for breast, colorectal, lung and prostate cancer at seven providers throughout the UK in 2009/10⁴⁷. It estimated how many patients likely to be entered to onto a supported self-management pathway for specific tumour types:

⁴⁶ A partnership between NHS England and Macmillan Cancer support

⁴⁷ <http://www.improvement.nhs.uk/LinkClick.aspx?fileticket=piHHerH%2FYd0%3D&tabid=56>

- Breast Cancer – 70per cent
- Prostate Cancer – 40per cent
- Colorectal Cancer – 40per cent
- Lung cancer – 15per cent

Supporting patients to self-manage their own health and wellbeing can meet unmet needs, reduce demand on services and so reduce costs through removing a number of follow up outpatient appointments. To do this patients will need to be stratified according to their clinical and individual needs, the elements of the Recovery Package will need to be in place so that patients are equipped to self-manage and are signposted as to where they can go for both local support services and for surveillance and access to specialists should they have any concerns. Joint plans between local authorities, primary care and secondary care will be needed as the number increase to ensure that patients are provided good overall support.

Stratified pathways should assist in improving patient experience since they enable each patient greater choice in how their care and follow up is managed. The estimated net saving in England is £86 million, or £214,000 per 100,000 population⁴⁸.

3. The management of consequences of treatment

Side effects from cancer treatments are common and usually resolve themselves within a few months of treatment. However some side effects continue and can affect the quality of both physical and psychosocial health. There are currently only estimates as to the number of patients suffering from long term side effects as consistent recording of patients' health notes does not always happen.

Whilst much of the Recovery Package for cancer patients aligns with services already commissioned for patients with other long term conditions, it is imperative that specific support for conditions relating to side effects of treatment are commissioned. The areas outlined below have been prioritised in London.

Lymphoedema

It is estimated lymphoedema affects between 80,000 and 124,000 people across England per year⁴⁹. The South West London Community Trust study found that lymphoedema affected 1.33 per 1000 people of all ages. This is a chronic condition and if not treated correctly can result in long term disabilities and reduce quality of life.

The NHS saves an estimated £100 in reduced hospital admissions for every £1 spent on lymphoedema treatments that limit swelling and prevent damage and infection⁵⁰.

⁴⁸ Stratified cancer pathways: redesigning services for those living with or beyond cancer. Quality & Productivity: Proven Case Study (2013)

⁴⁹ <http://www.macmillan.org.uk/Documents/AboutUs/Commissioners/LymphoedemaServicesAnEvidenceReview.pdf>

⁵⁰ Cancer And Palliative Care Rehabilitation: A review of the evidence (NCAT 2012); Cancer Rehabilitation; making excellent cancer care possible (NCAT 2013); Macmillan's Routes from Diagnosis Programme (2013)

From year one of the strategy, MDTs will be required to provide evidence of a referral pathway to lymphoedema service.

Pelvic radiation disease

Pelvic radiation disease can occur after pelvic radiotherapy and can cause long term effects on the bowel, bladder and sexual function. However simple interventions advising patients on both the possibility of negative side effects such as providing a 'toilet card' and/or radar key, doing pelvic exercises or moderating the intake of dietary fibre or fat, allow some people to better self-manage and potentially avoid more serious problems. These simple interventions are currently not standard and not offered to everyone.

From year one of the strategy, MDTs will be required to provide evidence of a referral pathway to a named gastroenterologist with a lead interest in that area.

Treatment related sexual problems

53per cent men and 24per cent women receiving radiotherapy treatment to their pelvic areas report issues with maintaining a sexual relationship with effects persisting up to 11 years after treatment⁵¹. Treatments and support are available but not routinely offered. From year one of the cancer commissioning strategy, MDTs will be required to provide evidence of a referral pathway to sexual dysfunction support.

⁵¹http://www.macmillan.org.uk/Documents/AboutUs/Newsroom/Consequences_of_Treatment_June_2013.pdf

Assessment of the living with and beyond cancer interventions

Living with and beyond cancer				
Intervention	Patient outcomes	Patient experience	Readiness to deliver	Notes
Recovery package (HNA, treatment summary and health and wellbeing event)				
Health and wellbeing (including physical activity, work and finance)				
Risk stratified pathway				Modelling work is underway
Lymphoedema services				
Pelvic Radiation disease services				
Sexual dysfunction services				

Guide

For patient outcomes and experience:

- Green indicates high impact
- Amber indicates medium impact
- Red indicates low impact.

For readiness for implementation by commissioners:

- Green indicates readiness in year one
- Amber indicates readiness in year two
- Red indicates readiness in years three – five of the strategy.

9. End of Life Care

Recommendations for commissioners:

It is recommended that CCG commissioners:

- Commission the *Coordinate my Care* system now that it has proof of concept.

Around 70% of people would prefer to die at home only 42% do nationally and the proportion in London is even lower at approximately 35%, the lowest across all the regions⁵². London also has the highest average length of hospital stay for people with a terminal illness compared to other regions in England⁵³. The majority of patients die in hospital and yet this is not their first choice of location for place of death.

A Pan London End of Life Alliance was launched in November 2013 bringing together key partners from CCGs, local authorities, NHS and independent providers, the voluntary sector and patient and carers groups with the aim of supporting and promoting patient-centred, coordinated care commissioning and delivery across London. It is expected that this alliance will be an important resource for commissioners in improving end of life care across the capital.

One example of changes that have been made to the care pathway to increase the coordination of care for patients at the end of their life and supporting more people to die in their preferred place of death is *Coordinate My Care* (CMC). CMC is a way of managing the treatment of patients who are nearing the end of their lives. The approach focuses on the coordination of multiple providers and aims to improve the efficiency of delivery of end of life care, ensuring a more integrated experience for the patient. CMC promotes choice for patients.

Findings from the first year of CMC in London found that patients using CMC make less use of hospital, emergency and unplanned care. For example, the average number of hospital inpatient attendances is 1.7 for CMC patients and 2.3-2.6 for non-CMC patients⁵⁴.

CMC patients also make greater use of community services. For example, CMC patients have approximately 15.5 GP surgery encounters compared with 10.0-10.4 for non-CMC patients.

The per-patient cost of hospital, emergency and unplanned care is £2,324,467 lower for CMC patients compared with non-CMC patients. The cost of community services is £365-974 higher. The net impact is that average treatment costs for CMC patients are £1,350-2,102 lower than for non-CMC patients⁵⁵.

⁵² <http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/11/ldn-cta.pdf>

⁵³ Data: Hospital Episode Statistics (HES) from Public Health England (NEoLCIN). End of life care profiles summary statistics 2008 to 2010. Forthcoming 2013.

⁵⁴ Frontier Economics: End-of-life care – CMC pilot cost analysis; June 2013

⁵⁵ Frontier Economics: End-of-life care – CMC pilot cost analysis; June 2013

The most recent report⁵⁶ from CMC shows that the system enabled 79per cent of people registered with CMC to die in their first preferred place of death.

NHS England now has proof of concept for CMC and is working with the office of the CCGs to develop a Locally Enhanced scheme to incentivise CCGs to implement it.

⁵⁶ CMC Monthly Data Overview; Last Updated: 8 January 2014

D. The enablers to deliver the strategy

At this stage, these are not fully developed but will include:

- Workforce and education

A consideration of what changes, restructure, education and additional investment needs to be made in both primary and secondary care workforce to deliver this strategy. Examples include a review of multi-disciplinary teams, primary care education of cancer signs and symptoms and investment in the endoscopy workforce to meet the growing demand for endoscopy services.

- Informatics

Commissioners will need to consider what information is required to monitor the implementation of this strategy and to be assured that cancer outcomes are improving.

- Commissioning and contracting

Commissioning and contractual levers will support the implementation of many of the initiatives proposed.

- Research

It is recognised that research drives the quality of clinical care. There is some evidence that patients who are treated in centres where clinical trials take place do better. Currently there is wide variation in access to clinical trials across London's providers. Research needs to cover the whole spectrum across the cancer care pathway from prevention to early detection to all forms of treatment to survivorship and end of life care. Commissioners will need to consider what levers they can pull to ensure an optimum environment to stimulate research.

- Communication

Communication between Primary and Secondary Care clinicians and between health care professionals and patients comes up time and again as barriers to the delivery of excellent care.

E. Summary and assessment of recommendations made by each workstream

Each recommended intervention has been assessed against its impact on patient outcomes, patient experience and its readiness to be implemented or supported by commissioners. For readiness, a green rag rating indicates it is ready to be implemented by commissioners in year one; amber in year two and red in years three to five.

Early detection and awareness				
Intervention	Patient outcomes	Patient experience	Readiness to deliver	Notes
Rapid access clinics for high risk populations				
CT scan for high risk population of lung cancer				
HCC surveillance				
Breast cancer – over 70s				
Raise population awareness of specific signs and symptoms				
Utilising healthcare touch points				Pilots in year one
Utilising non healthcare touch points				Pilots in year two
Roll out of the Cancer Decision Support tool				
Managing procedures in community settings: skin lesion excision				
Greater access for GPs to CT scan for vague abdominal symptoms				
Development of best practice pathways				
Continual learning – Primary Care				
Practice profile				
Endoscopy for Lower GI				
Endoscopy for Upper GI				

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Reducing variation and service consolidation London Cancer Alliance				
Intervention	Patient outcomes	Patient experience	Readiness to deliver	Notes
Breast - 23 mastectomy				
Breast - immediate breast reconstruction				
Breast - metastatic management				Modelling work is underway
Breast – timely/ equitable access				
Lung - resection rates				
Lung - treatment for over 70s				
Colorectal - laparoscopic surgery				
Colorectal - major resection				
Acute oncology services				
Diagnostics - imaging				
Complex molecular diagnostics				
Rarer cancers - Consolidation of services				

Reducing variation and service consolidation London Cancer				
Intervention	Patient outcomes	Patient experience	Readiness to deliver	Notes
Breast - 23 mastectomy				
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Lung – laparoscopic surgery				
Lung - treatment for over 70s				
Colorectal - laparoscopic surgery				

Colorectal - major resection				
Acute oncology services				
Diagnostics - imaging				
Complex molecular diagnostics				
Rarer cancers - consolidation of services				

Chemotherapy				
Intervention	Patient outcomes	Patient experience	Readiness to deliver	Notes
Chemotherapy closer to home				
Home delivery of oral chemotherapy				
Implementing use of subcutaneous formulation				Modelling work is underway

Radiotherapy				
Intervention	Patient outcomes	Patient experience	Readiness to deliver	Notes
Stereotactic Ablative radiotherapy				
Hypofraction				

Patient experience				
Intervention	Patient outcomes	Patient experience	Readiness to deliver	Notes
Travel and parking				
Systems and waiting times				
Staffing levels				
Behavioural issues				
Transitions between settings of care				
Primary Care				

Living with and beyond cancer				
Intervention	Patient outcomes	Patient experience	Readiness to deliver	Notes
Recovery package (HNA, treatment summary and				

health and wellbeing event)				
Health and wellbeing (including physical activity and work and finance)				
Risk stratified pathway				Modelling work is underway
Lymphoedema services				
Pelvic radiation disease services				
Sexual dysfunction services				

F. Conclusion

Cancer is a key priority for the NHS in London. Whilst there are pockets of excellence in London, there are also areas of wide variation in early detection, access to cancer treatment and services, standards of care, support offered following a cancer episode and at the end of life.

This strategy provides the latest view of the key areas over the next five years with a particular emphasis on the next two years. If London is to transform cancer services, improve cancer outcomes and radically change cancer experience, accelerated implementation of the *Model of Care* as well as action on those areas where evidence has emerged since its publication will be essential.

Commissioners are asked to support the recommendations made in the cancer strategy and to give consideration to these areas in the development of local plans in line with the *Call to Action*.