

Five year
Cancer commissioning
Strategy for London

April 2014



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Five year Cancer Commissioning Strategy for London

“It’s so important that all commissioners and Health and Wellbeing Boards throughout London make cancer a priority to help make these strategies described a reality and success; and get the best for patients both in outcomes and experience, accepting that many of the shortfalls are due to the system.”

Bonnie Green, Cancer patient and carer

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. However 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 rates³. 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 30percent 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

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](https://www.ons.gov.uk/health-and-social-care/cancer/figures-and-statistics/local-and-regional) (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>

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.

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. It was endorsed by London's Cancer Commissioning Board at its March 2014 meeting⁹.

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.

A number of key stakeholders from across the cancer community – from CCG commissioners, Integrated Cancer Systems, cancer clinicians, Specialised Services Commissioning, Screening commissioning, Public Health, cancer patients and carers and cancer charities in London were involved in developing the strategy dedicating a huge amount of time to researching and engaging with clinicians and patients to write each section. Many thanks to those who collated information and feedback from clinicians and commissioners and who authored the various parts of the strategy.

These include:

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Jo Locker, Tobacco Control Delivery Manager, National Centre for Smoking Cessation and Training
Lily Makurah, Health Improvement Manager, Public Health England – London
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Laura Boyd, Senior Implementation Lead, NHS England (London Region)
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⁶ Please see Reducing Variation and Service consolidation section of the strategy

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

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

⁹ For full membership of the Cancer Commissioning Board, please see appendix 4

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Jo Champness, Senior Service Specialist , Blood & Cancer NHS England London Region
Paul Roche, Interim Programme Director, Transforming Cancer Services for London
Andy Mcmeeking, Cancer Commissioning Team Manager, North and East London
Commissioning Support Unit
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The detailed strategies that underpin each of the workstreams are available on request. Please contact cerrie.baines@nhs.net.

Plans to implement year one of the strategy have been developed. Modelling work is also underway to understand the costs associated with this work and to understand the full extent of the benefits that will be realised as a result of implementation.

Support is available for the implementation of the five year cancer commissioning strategy through the Transforming Cancer Services Team which is accountable to the Cancer Commissioning Board on behalf of both CCGs and NHS England. The team has strong local presence through its regional cancer clinical leads and support team and can provide support with commissioning and contracting, implementing early detection plans and developing plans for those living with and beyond cancer. Please contact teresa.moss@nwlcsu.nhs.uk for further information about the team and its work.

B. Introduction

In 2009, the *Case for Change*¹⁰ 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.

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

¹⁰ <http://www.londoncancer.org/media/11798/cancer-case-for-change.pdf>

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. 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.

This strategy is a refresh of the *Model of Care* 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.

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*¹¹ 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

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

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. [Please see appendix 2 for a report from the 2013/14 engagement events.]

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 have been reflected in the refreshed strategy.

Table 1: CCG priorities as recorded at the 2011/12 and 2012/13 engagement events

Themes	Early detection & awareness	Screening	Living with and beyond cancer	Improving Communication	Data transparency
Priorities	Initiatives to drive up the earlier diagnosis of: Colorectal cancer Upper GI cancer Lung cancer	Improving coverage and uptake of the three cancer screening programmes with emphasis on bowel screening. Agreement that local changes could greatly improve the national screening programmes	HNAs to include psychological assessment Treatment Summary should be standard	Communication – letters from secondary care to primary care to be improved so that GPs understand what is expected of them	Transparency as to progress made in implementing the model of care needed Publish length of stay variation
	Practice profile work & GP education	Greater sharing of data as to take up at a practice level needed	Primary Care Cancer Care Review to be an on-going review	Letters written in appropriate languages	Performance & cost data
	Increasing capacity of flexi sigmoidoscopy and colonoscopy for lower GI	Reduction of variation in uptake in secondary care	Early discharge and enhanced recovery after surgery	More “user friendly” letters for patients	
	Implementation of RCGP/RCR response times for GP diagnostics	Raise public awareness of the screening programmes	Role of primary care	Standardisation & use of templates	
	Awareness and appropriate use of referral routes		Joined up palliative care	Regularity & content of communications	

From both sets of engagement events, clear priorities stand out:

- the importance of earlier detection
- the need to improve coverage and uptake of screening
- the need to support people living with and beyond cancer as a long term condition
- the importance of information and data as to the cost and performance of services
- the vital need for excellent communication

These themes have been incorporated into this five year cancer commissioning strategy.

Development of the strategy

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 (PLCUP) consists of cancer patients and carers from across London which meets regularly to provide feedback on the cancer programme. Each workstream, during development, has been taken to the PLCUP meeting for input during 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 ensure progress was made. Again clinicians, commissioners, the ICSs and charity partners made up this steering group.

In January 2014, a pan London Cancer Commissioning conference was held for all commissioners involved in cancer across the capital. The strategy was presented at the conference and commissioners were then asked for feedback as to the priorities set out. The purpose of the conference was to:

- Engage with all commissioners across London to influence the shape and development of the five year cancer strategy and, through this, developing plans for cancer within 'A call to action'
- Discuss those areas of improvements in cancer services that commissioners can make a significant difference to, including new thinking on the impact of cancer on primary care and cancer as a long term condition, as well as the need to commission improvements in acute providers
- Build on the work undertaken in 2012 and 2013 to ensure that effective cancer planning is based on the 2010 'Model of Care' with new insights gained from CCG engagement and new developments
- Ensure cancer is seen as a priority for all commissioners
- Ensure that the patient perspective is understood in all decision making

Overall feedback received about the conference was positive with 86% feedback from respondents agreeing they would "*ensure the themes highlighted at the conference would be incorporated in to my organisation's commissioning strategies/plans.*"

Delegates at the conference expressed general support for the strategy themes and reinforced the importance of:

- Early detection and awareness of cancer
- The role that commissioners play in reducing variation
- The importance of supporting the growing number of Londoners living with and beyond cancer

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 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 on page 12.

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.

Health and Wellbeing boards are asked to influence local commissioning arrangements to ensure measures to prevent cancer and other diseases are embedded across all activities and support the reduction in health inequalities.

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 43percent cancers are attributed to lifestyle and environmental factors¹² 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* review¹³ 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 19.4percent of all new cancer cases in 2010 equating approximately to one in five cancers. 90percent of lung cancers are associated with cancer¹⁴. 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

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 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

¹⁴ <http://www.cancerresearchuk.org/cancer-info/cancerstats/types/lung/riskfactors/lung-cancer-risk-factors>

- Ensuring all local health care professionals/practitioners are trained in delivering Very Brief Advice¹⁵ on smoking and know where to refer or signpost people to if they are interested in taking action to stop or reduce their smoking
- Ensuring all secondary care providers follow recent NICE guidance¹⁶ 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 smokefree
- 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.

The role of Primary Care

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. Work is currently taking place 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 43percent 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 that are available.

¹⁵ http://www.ncsct.co.uk/publication_very-brief-advice.php

¹⁶ <http://guidance.nice.org.uk/PH48/>

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 4percent of the total NHS budget is spent on prevention¹⁷.

Working with Local Authorities

Working with Local Authorities to exploit opportunities to incorporate healthy living messages within existing communications and projects offers a great opportunity to not only help prevent many cancers but also a host of other preventable illnesses. By keeping residents healthier for longer we can ensure people are able to stay within the workplace and, ultimately, reduce the burden on both health and social care.

¹⁷ <http://www.england.nhs.uk/wp-content/uploads/2013/11/call-to-action-com-prev.pdf>

2. Cancer screening

CCG commissioners during both the CCG engagement events and the Cancer Commissioning conference recognised the contribution that screening has made to improving cancer mortality and morbidity. However whilst they recognised the clinical quality of the programmes, they agreed that there is scope to improve the coverage and uptake as well as the equity of uptake of the three cancer screening programmes across London.

Recommendations for commissioners in years one and two

It is recommended that NHS England Screening commissioners:

- Improve integration between providers across the screening pathway- including screening providers (primary, community and secondary care), diagnostic services (pathology, imaging) and treatment services
- Strengthen collaborative working with other commissioners of screening and related services including local authorities, CCGs, primary care
- Ensure services in London meet national quality and performance standards
- Develop services to meet the needs of Londoners
- Improve patient experience of screening services
- Support PHE and providers in the piloting and roll-out of new screening programmes including breast screening age extension, bowel scope screening¹⁸ and HPV primary 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 leads to champion screening
- Work with local community groups (facilitated through links with local authority public health teams) to deliver messages to support 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

The national screening programmes for cancer are approved by the National Screening Committee with the support of Public Health England and commissioned by NHS England.

¹⁸ (Bowel Scope is a new screening programme inviting people around their 55th birthday for a Flexible Sigmoidoscopy examination of the lower bowel)

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 London¹⁹. Patient experience is not systematically measured across all screening services.

New cancer screening programmes such as Bowel scope for 55 year olds, are being introduced across London offering new opportunities to prevent and diagnose cancers earlier. Breast screening now provides screening for women at high risk of breast cancer due to their family history. Other developments will be introduced in line with national policy.

Other potential programmes are being explored at a national level, for example CT screening for populations at high risk of lung cancer. There is evidence that screening persons aged 55 to 74 years who have cigarette smoking histories of 30 or more pack-years and who, if they are former smokers, have quit within the last 15 years reduces lung cancer mortality by 20percent and all-cause mortality by 6.7percent²⁰. London Cancer is exploring a pilot in this area and further details are included within the Early Detection and awareness section of this document.

To maximise the impact of new and existing programmes, it is vital coverage and 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 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
- Facilitate high quality research to further inform strategies to improve coverage and uptake in London.

¹⁹ Cancer Awareness Measures undertaken across London

²⁰ National Cancer Institute, Randomised Control Trial

(<http://www.cancer.gov/cancertopics/pdq/screening/lung/HealthProfessional/page1/AllPages>)

3. Early diagnosis and awareness

CCG commissioners during both the CCG engagement events and the Cancer Commissioning conference agreed that improving the earlier detection of cancer is a priority for London.

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 who 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
- Use the CCG briefing sheets on early detection to be developed by the two Cancer Commissioning Teams to inform planning in improving earlier detection of cancer within their areas

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.

Over the last year, work has been undertaken at a local level (via the two Cancer Commissioning Teams and Integrated Cancer Systems) and pan- London to develop once

for London best practice commissioning pathways and an endoscopy strategy for Lower Gastro intestinal cancers.

Local work has focussed on working with primary care to:

- Disseminate information about the national *Be Clear on Cancer* campaigns to GPs, pharmacies and other local healthcare settings
- Improve GP recognition and awareness of cancer signs and symptoms
- Improve the quality and timeliness of referrals
- Support practices to understand the particular demographics of their local populations which impact the nature of its local cancer incidence and outcomes.

For each CCG, a briefing sheet is being developed detailing the local challenges in cancer incidence, mortality, referral rates, screening uptake etc. and complemented by public health information as to local demographics and an understanding of the evidence as to what has worked previously. The briefs are focussed on early detection and include recommendations about what would support earlier detection in each CCG and contain an offer of developing individual CCG action plans. They will be available at the end of March 2014.

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.

Across London, 25percent - 30percent 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. Reducing the number of people first diagnosed in A&E must be a priority in order to improve cancer outcomes in London.

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 greatest²¹:

- Bowel
- Lung
- Breast.

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

- Ovarian

²¹ Abdel-Rahman et al, BJC Supplement December 2009

- Oesophago-gastric.

Melanoma or skin cancer is also prioritised because of the growing incidence and mortality rates²². 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, the shops encourage people to talk about cancer in a non-clinical environment conveniently located in the community²³. 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 the GP or other suitable service. From year one of the strategy, all dentists will have cancer checks written into their contracts as standard. Additionally pharmacies are required to promote six 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 saw 700 [equivalent to 10% more people than in the same months during the previous year] extra people diagnosed with lung cancer. Many of these

²² Cancer Research UK: <http://www.cancerresearchuk.org/cancerinfo/cancerstats/types/skin/incidence/#trends>

²³ Evaluation of the 'Get To Know Cancer' pop up shop initiative; 2013, Kings College London

additional diagnoses were at an early stage and resulted in 300 more patients getting surgery, offering the best chance of prolonged survival.²⁴

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 – many of whom are cancer survivors to be able to talk about cancer signs and symptoms and the importance of early detection. A key aim of the programme is to demonstrate that there can be life after cancer to overcome the fear and fatalism that is often associated with cancer.

In December 2013 the programme trained fifteen 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, 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 to 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 undertaken by Durham University²⁵ as to the NAEDI/ Cancer Networks support of primary care which analysed the impact of practices that undertook practice profiles, risk assessment tools, clinical audit and significant event audits, found that:

- Emergency presentation rates decreased by 2.3 percentage points (from 23.4percent to 21.1percent)
- Cancer detection rate rose by 3.9percent

²⁴ Cancer Research UK; *Be Clear on Cancer* evaluation

²⁵ Durham University: Final report- the NAEDI/ Cancer networks, Supporting Primary Care Programme 2012 to 2013

- Variation in referral practice was less for those practices that had an intervention(e.g. a practice profile) In place

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 Cancer Support and early evaluation shows a positive result²⁶. 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*²⁷, for:

- Non obstetric ultrasound
- Chest X-ray
- Flexible-sigmoidoscopy
- Brain Magnetic Resonance Imaging.

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 exploring with the clinical community whether direct access for CT scan is or could be 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.

²⁶ Interim evaluation to be published in February 2014

²⁷https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213785/dh_123394.pdf

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 accredited²⁸, 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 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.

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 40percent and 60percent²⁹ 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

²⁸ <http://www.thejag.org.uk/>

²⁹ As noted in London borough's JSNAs

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 80-90percent of patients with HCC³⁰. 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.

Enabling strategies

Enabling strategies are set out in Section D – *Enabling strategies to deliver this strategy*- later in this document. Key to the delivery of the early detection and awareness strategy will be those focussing on primary care education to support improved understanding of cancer signs and symptoms and referral rates as well as commissioning levers – particularly primary care commissioning and CCG commissioning of new diagnostic pathways.

³⁰ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3036965/>

Benefits of earlier detection – what could be achieved in London

2009 figures show that just 6.9percent patients are diagnosed at stage A of colorectal cancer when survival rates are 93percent with the majority of people (around 70percent) diagnosed at stages C and D or unknown when survival rates drop to 47percent and 7percent respectively. By increasing screening uptake, supporting the public to present symptoms quickly, ensuring GPs refer along the two week wait referral pathway promptly and eliminating delays in secondary care endoscopy capacity, clinicians in London believe we could increase the percentage of patients diagnosed at stages A and B to around 70percent when survival rates are 93percent and 77percent respectively. In this way we could greatly improve colorectal cancer outcomes for London.

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 the 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. Commissioners can assess IOG compliance using the results of the National Cancer Peer Review

Breast cancer:

It is recommended CCG commissioners:

- Commission along the best practice commissioning pathway for breast cancer to reduce variation in care and treatment for patients
- 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

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 achieve the [faster] reporting time for diagnostic tests
- Commission along the three early detection best practice commissioning pathways for lung, colorectal and ovarian cancers in order to increase the speed at which patients receive a cancer diagnosis

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 changed 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 for common cancers where work has been prioritised are summarised:

1. Breast cancer

In 2012, there were 4876 diagnoses of breast cancer in London³¹ 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

³¹ ENCORE; Cancer Analysis System, 2012 figures

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 44percent to 96.4percent across London's providers³².

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 level can only serve to improve both patient outcomes and experience as metastatic diagnosis is reached quickly and the patient is 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 2012³³. Alarming lung cancer rates are increasing in women in many London boroughs³⁴. 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

³² NCIN – cancer commissioning toolkit – National breast service profile

³³ ENCORE; Cancer Analysis System, 2012 figures

³⁴ As noted in Joint Strategic Needs Assessments across London

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 resection³⁵. The variation in resection rates for lung cancer patients treated across London's provider organisations shows rates ranging from 2.4percent to 31percent³⁶. 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.

Lung cancer treatment in the over 70s

Evidence shows that the over 70s are less likely to receive active treatment for lung cancer³⁷. 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 2012.³⁸ Between 1971 and 2008, incidence rates for colorectal cancer increased by 33percent for men and 12percent for women. In 2008, colorectal cancer accounted for 14percent of all new cancer diagnoses in men (57 new cases per 100,000 population) and 12percent in women in England (37 new cases per 100,000)³⁹.

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 11percent to 84percent⁴⁰.

³⁵ Riaz et al 2011

³⁶ Lung cancer resection rates for patients in 2012; LUCADA – 2013 report

³⁷ Age, comorbidity, treatment decision and prognosis in lung cancer; Oxford Journals 2008

³⁸ ENCORE; Cancer Analysis System, 2012 figures

³⁹ <http://www.ons.gov.uk/ons/rel/cancer-unit/bowel-cancer-in-england/2008/colorectal-cancer-in-england-2008.html>

⁴⁰ 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 23 days. Emergency readmission can range from 8percent to 30percent across the London Cancer Alliance and from 9.7percent to 44.7percent across London Cancer. 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 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 anticipated 1695 bed saving days per annum plus an estimated annual saving of £476,631⁴¹. 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.

Where closures of A&E departments are taking place in London, ensuring patients and paramedics are aware of the closest AOS department will be vital so that cancer patients get the appropriate care and treatment needed as quickly as possible

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*⁴² which sets out minimum turnaround times for reports. To reduce delays in reaching a diagnosis, it is

⁴¹ Chelsea and Westminster example of AOS: Acute Oncology Dr Thomas Newsom-Davis Consultant Medical Oncologist

⁴² <http://www.rcgp.org.uk/revalidation-and-cpd/~media/Files/CfC/RCGP-Quality-imaging-services-for-Primary-Care.ashx>

recommended all providers adopt the recommendations set out in the RCR and RCGP report.

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

London Cancer Alliance (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*⁴³ 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

⁴³ <http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/10/ldn-tec-pack.pdf>

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.

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.

Enablers

Enabling strategies are set out in Section D- *Enablers to deliver the strategy*. Key to the delivery of the Reducing Variation and Service Consolidation strategy will be the research, data and information and commissioning levers strategies.

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				
Breast - immediate breast reconstruction				
Breast - metastatic management				
Breast – timely/ equitable access				
Lung - resection rates				
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				

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For readiness for implementation by commissioners:

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- Red indicates readiness in years three – five of the strategy.

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 increase 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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For readiness for implementation by commissioners:

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- Amber indicates readiness in year two
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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 a 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 cancers⁴⁴. SABR capacity in London has increased rapidly but without an evidence base or formal approval from commissioners. Year one of this strategy therefore proposes to lead a project to determine the potential for commissioning the evaluation of comparative treatment delivered 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 results⁴⁵.

⁴⁴ National Cancer Action Team, 2011; <http://www.england.nhs.uk/wpcontent/uploads/2013/08/b01-p-a.pdf>

⁴⁵ 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
Sterotactic Ablative radiotherapy				
Hypofraction				

Guide

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- Green indicates high impact
- Amber indicates medium impact
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For readiness for implementation by commissioners:

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

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

38percent of patients had to wait longer than 15 minutes for an appointment and 39percent were not told how long they would have to wait⁴⁶. Long waiting times for appointments

⁴⁶ 2011 Outpatients survey

compound the impact of travel times and costs and can add to the stress and anxiety of appointments or undergoing treatment.

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 (CNS) 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.

Celebrating success where things have worked well and learning from good practice will also be vital in moving towards positive behaviours.

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 the system 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.

Underpinning each of the six priority areas for patient experience is the need for improved communication and information both for patients – from how their diagnosis is explained to what support is available post treatment – and for medical professionals involved at different stages along the cancer pathway – to ensure transition between settings of care is as smooth as possible.

It will be important that as plans develop around Primary Care Transformation in London, these areas are considered for improvement.

Assessment of the patient experience interventions

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				

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.

8. Living with and beyond cancer

Recommendations for commissioners

Elements of the National Cancer Survivorship Initiative-recommended 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.

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, sexual dysfunction support and psychological support

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

It is recommended that Commissioners and Primary Care work together to improve the quality and delivery of the Cancer Care Review

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 with and beyond cancer, and greater numbers of Londoners acting as carers for people with 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. There will also be a need to support the increasing numbers of carers looking after family members and loved ones so that they are equipped both physically and psychologically to provide care.

The *Model of Care* recommended that every patient receives 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 Cancer Support, published the National Cancer Survivorship Initiative: *Living with and beyond cancer: taking action to improve outcomes*⁴⁷ 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 Recovery Package

The Recovery package (developed by NCSI) comprises:

- Holistic Needs Assessment (HNA)
- 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, and on-going needs addressed thereby resulting in improved patient satisfaction and 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 financial support, where appropriate.

The Treatment Summary documents the care provided, informing the GP and patient about prognosis and planned future care, highlighting signs and symptoms of recurrence and consequences of treatment. It must give a robust direction for the greater involvement and

⁴⁷ <https://www.gov.uk/government/publications/living-with-and-beyond-cancer-taking-action-to-improve-outcomes>

commitment from primary care and community services if those living with and beyond cancer and their carers are to see an improvement in their care and support.

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

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

It is expected the Recovery Package will deliver improved patient satisfaction and outcomes and 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 Initiative⁴⁸ 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 2009/10⁴⁹. It estimated how many patients likely to be entered onto a supported self-management pathway for specific tumour types:

- Breast Cancer – 70percent
- Prostate Cancer – 40percent
- Colorectal Cancer – 40percent
- Lung cancer – 15percent

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 numbers 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 population⁵⁰.

⁴⁸ A partnership between NHS England and Macmillan Cancer support

⁴⁹ <http://www.improvement.nhs.uk/LinkClick.aspx?fileticket=piHHerH%2FYd0%3D&tabid=56>

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 since 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.

Physical activity

Current evidence supports the recommendation of exercise and the numbers of people living with & beyond cancer who are supported to increase their level of activity should be maximised:

- During treatment to prevent decline in functional outcomes without increasing fatigue;
- After treatment to support effective recovery of physical function; and
- 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.

⁵⁰ Stratified cancer pathways: redesigning services for those living with or beyond cancer. Quality & Productivity: Proven Case Study (2013)

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 69percent 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 90percent 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.

Lymphoedema

It is estimated lymphoedema affects between 80,000 and 124,000 people across England per year⁵¹. 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 infection⁵². 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.

⁵¹ [http://www.macmillan.org.uk/Documents/AboutUs/Commissioners/LymphoedemaServicesAnEvidenceReview.p](http://www.macmillan.org.uk/Documents/AboutUs/Commissioners/LymphoedemaServicesAnEvidenceReview.pdf)

⁵² 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 a named gastroenterologist with a lead interest in that area.

Treatment related sexual problems

53percent men and 24percent women receiving radiotherapy treatment to their pelvic areas report issues with maintaining a sexual relationship with effects persisting up to 11 years after treatment⁵³. 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.

The Cancer Care Review

The Cancer Care Review (CCR) plays an important part in the living with and beyond cancer agenda and, as such, needs to be developed and improved. The Quality and Outcomes Framework (QOF) requires all patients diagnosed with cancer to receive a CCR by their GP within six months of the GP practice being notified that the person has a cancer diagnosis.

The QOF lacked clarity surrounding what the CCR should consist of and what is helpful and necessary to include. As a result the patient experience is variable.

Most GPs understand that a CCR is about a conversation with the patient to get a sense of their understanding, answer any queries and assess support needs, however, there is a need for improved structure and quality. The NCSI has worked with Macmillan Cancer Support in the development of a CCR template to improve the quality and delivery of the CCR.

Implementing the Living with and beyond cancer strategy

Enabling strategies are set out in section D. Key to the delivery of the Living with and beyond cancer strategy will be those enablers concerning primary care education, data and information and commissioning.

⁵³http://www.macmillan.org.uk/Documents/AboutUs/Newsroom/Consequences_of_Treatment_June2013.pdf

Cost benefit case study: potential impact of the Recovery Package

It is estimated that conducting a Holistic Needs Assessment takes around one hour of nursing time. The cost of this proactive care planning can be offset by reduced unplanned contact, as it ensures that patients have appropriate information and a clear management plan.

There is evidence from NCSI test sites that this approach can help reduce emergency admissions and other forms of health service utilisation, as well as evidence that proactive care is a more efficient way of planning support.

Routine one to five-year follow-up of cancer survivors within the NHS costs in the region of £250 million per year out of a £6 billion per year budget. This is currently delivered through a mainly medical model using consultant outpatient appointments and associated diagnostic tests. The case for routine follow-up as an effective method to pick up early recurrence or disease progression is not strong.

For lower-risk patients, a stronger emphasis on holistic care planning to sustain recovery, manage the consequences of treatment and reduce the risk of recurrence should be affordable without compromising early recurrence detection; indeed it may even improve this. The estimated net saving in England is £86 million, or £214,000 per 100,000 population.

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 42percent do nationally and the proportion in London is even lower at approximately 35percent, the lowest across all the regions⁵⁴. London also has the highest average length of hospital stay for people with a terminal illness compared to other regions in England⁵⁵. 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 patients⁵⁶.

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 patients⁵⁷.

⁵⁴ <http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/11/ldn-cta.pdf>

⁵⁵ Data: Hospital Episode Statistics (HES) from Public Health England (NEoLCIN). End of life care profiles summary statistics 2008 to 2010. Forthcoming 2013.

⁵⁶ Frontier Economics: End-of-life care – CMC pilot cost analysis; June 2013

⁵⁷ Frontier Economics: End-of-life care – CMC pilot cost analysis; June 2013

The most recent report⁵⁸ from CMC shows that the system enabled 79percent 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 London CCGs to develop a Locally Enhanced scheme to incentivise CCGs to implement it.

⁵⁸ CMC Monthly Data Overview; Last Updated: 8 January 2014

D. The enablers to deliver the strategy

Workforce education, research, commissioning levers and data and information were all identified as enablers for implementing the five year cancer commissioning strategy.

A. Education and workforce (Primary Care)

Introduction

Earlier stage diagnosis of cancer and effective shared management after treatment are areas that fall within the remit of the primary care team. In both domains, there is an underlying theme of a managed clinical pathway for cancer in primary care. This is a new concept and has developed through the appearance of different tools and evidence over the last five years.

Practices can now review and reflect on their own cancer metrics, with the option of comparing their activity with CCG and national averages. There is access to computerised decision support software, which can search the practice database to identify patients at higher risk of cancer. The Royal College of General Practitioners (RCGP) has conducted a large project using practice level data to deliver a new cancer diagnosis audit. Last year the RCGP ran a pilot looking at using Significant Event Analysis data in a systematic way with moderated feedback on submitted information. Some CCGs are encouraging practice staff training using an on line tool that offers training that is role appropriate.

This tool can be used for social care settings, pharmacies and prison staff. Practice teams are of varying sizes across London and have limited access to resources for education and training. The cancer agenda requires changes in practice systems and behaviour if the goals of earlier diagnosis and effective support are to be met. There is no systematic approach to cancer education and training for primary care as a whole. This paper seeks to start development of a strategy for primary care.

The partners in the strategy will be Health Education London, AHSNs, CCGs and education material providers including charitable organisations (Macmillan Cancer Support, Cancer Research UK and Prostate Cancer UK being among the largest but not the only partners).

Training for GP Registrars

GP training is managed by Health Education London with the London School of General Practice and administered by Local Education and Training Boards. The curriculum is owned by the RCGP. Within the curriculum, cancer is considered in the disease specific domains, for example, lung cancer in respiratory problems. There is no generic domain for early detection of cancer. GP registrars spend a year in a one to one educational placement in

practice and are supervised by an approved Trainer. The registrars attend structured local planned training at their placement hospital with support from their GP Programme leads.

Previous work at the North West London Cancer Network in partnership with Macmillan led to the development of a targeted educational resource exploring communication skills and knowledge of presenting features of cancer. This has been circulated to the 700 GP trainers in London.

The RCGP website includes a Cancer Education Hub signposting approved on line resources. BMJ Learning has a set of high quality on-line resources which are available free to all London based doctors.

There is significant value in skilling GP Trainers and Programme Leads to deliver a structured package of cancer specific training to their registrars, in order to ensure they are familiar with the concepts and practice. It has the advantage of using an existing network of trained educationalists who are supported in their educational needs already. The cancer training would become an established part of the training, linking into the CCG Domain 1 priorities. GP Trainers work in local professional support Trainer groups. A longer term objective would be to support one or two Trainers to be the groups' cancer champions, linking with the cancer commissioning team. This extends the reach of the team beyond cancer leads, into groups of practices.

There are established relationships with the London School of General Practice and collaborative working to deliver GP Trainer Training. Within that process is a new survey tool to explore Professionals awareness of cancer issues, developed in partnership with Cancer Research UK. This tool will allow assessment of impact and effectiveness of training. A firm commitment to establishing this agenda and working with delivery partners will create a sustainable cancer education policy for GP training.

Training for established GPs (aligned with re-validation processes)

All doctors are required to be part of a revalidation system which includes annual appraisal. This is a five-year cycle and is mandatory for GMC registration. GPs have to demonstrate continuous professional development of 250 hours over the five-year term. Appraisal is undertaken by a trained GP appraiser.

In London there is a shift from the traditional partnership model towards salaried posts and increasing use of locum practitioners. Provision of education and training for all these groups is essential since they will all be using investigation and referral routes to diagnose cancer. There is another group of professionals (nurse practitioners) who in many cases are seeing the same spectrum of conditions as a GP.

The overall agendas of earlier stage diagnosis, effective support during the cancer journey and shared/self-management within a survivorship phase will need a structured approach by primary care. Many of the principles of recall, review, partnership working and self-management are already used in managing other long-term conditions e.g. diabetes. Education and training would support practitioners and practices to develop sustainable changes in practice systems.

This training can be considered at personal, practice, CCG and London wide levels. As individuals, GPs have to submit two significant event analyses per year for their annual appraisal. There is also scope to include service improvement initiatives, audit and complaints. This gives potential for GP appraisers to signpost cancer resources as and when cancer is identified in one of these domains. Over a five-year period it could be desirable for cancer to be an area of focus, given its clinical importance.

There are existing toolkits and audits which can be used for this purpose.

At practice level, the cancer profiles show data relating to a key set of metrics including screening, use of investigations and referral. Practices are accustomed to using prescribing data (PACT) to modify practice. The profiles data can be used in a similar way. There are projects in London exploring the delivery and impact of using this data. The practice profile also allows objective assessment of change so then becomes a useful tool for revalidation. The RCGP new cancer audit is a reflective tool that relates to the previous years diagnosis of cancer. Completion by a practice and discussion at clinical meetings with specific changes has been an effective method of reflection. System change within a practice has to be negotiated and agreed by partners. It is likely that change can be facilitated if the practice is able to review its own data and apply established workable templates of care.

Provision of cancer education for this group is mixed. Some CCGs have adopted a proactive approach with CCG level or locality educational events. Impact may be greater if practice level educational meetings are held but with resource implications. Education of GP appraisers and trainers could lead to wider understanding of how to use the existing tools and knowledge. The existing resources online and in workshop format have been tested. The RCGP faculties can bring together groups of interested practitioners to learn about cancer. However it is clear that all practitioners could benefit so systems that can reach across London are more likely to deliver change.

Training for practice staff – Nurses, Health Care Assistants, receptionists

This set of staff is essential to providing a modern effective team of care. All practices employ administrative and nursing staff with many having community staff that work within the building but are employed by separate trusts. Traditionally education and training for this set of workers has focused around their specific roles. Some CCGs have resourced learning times within practice. The staff are generally female and often live within the practice area; many work part-time. There is no specific requirement for them to have education and training around cancer but patients do often mention medical concerns and have questions for the staff.

There is an online tool (Cancer awareness toolkit) that has been developed in Cumbria which is suitable for this set of staff. It uses elements of role-play and small group working to increase awareness and knowledge of cancer screening, the importance of early detection and practical ideas on how to apply this knowledge.

The tool has been used across CCG's and staff knowledge pre-and post-training can be assessed using a validated cancer awareness measure survey.

The NHS is a significant employer and it would be beneficial to offer this awareness training across secondary and primary care staff. If it were done with the explicit aim of sharing knowledge beyond that the individual to their family and friends unit, there is potential for change within communities. An advantage is that this online training can be accessed at home or work.

Training for community staff – Pharmacists and Dentists

Community pharmacists are delivering more consultations and/or viewed as partners in care. There are often open at times when general practice is closed. Pharmacists have been involved in particular initiatives around coughing, rectal bleeding and awareness of oral cancers. Currently there is a piecemeal approach with many projects showing small-scale benefits. The cancer awareness toolkit outlined above has a module for pharmacists. Review of the cancer component of pharmacist training and collaborative working with the London wide pharmacy groups is suggested.

Dentists have a key role in the identification and early referral of mouth cancers. There is a variable understanding of the two week wait system and referral pathways. A review of current dental practice and education which includes private and NHS providers would be a significant step forward. Sharing understanding of presentation of head and neck cancers as well as mouth cancers has been shown to increase awareness amongst dentists.

Training for Social Care staff – Residential and Nursing Homes

Social care staff working in residential and nursing care homes look after a frail elderly population at risk of cancer. Staff also work within the community providing essential visiting and support services. The set of patients that they work with are vulnerable to cancer. A review of staff awareness of cancer symptoms using the cancer awareness measure survey would highlight areas for education and training.

The cancer awareness toolkit does have specific modules for the staff. An advantage of this approach is that local authorities would also be involved. Given the large numbers of staff it could be possible to develop a program that can be delivered locally as part of approving homes and services.

Implementation issues

Setting an education and training agenda across London can establish principles and overall objectives of the agenda. There needs to be local engagement and partnership. This would ideally happen at CCG level with local authorities and public health engagement to identify specific health needs. Setting this agenda into Health and Well Being board plans establishes the priority that is given. Many plans already include cancer and so education and training can be seen as an essential part of delivery. Some CCGs have existing agendas for earlier diagnosis so flexibility is required. All CCG's have domain one data (preventable deaths under the age of 75). There is a system of incentivising reduction in preventable deaths with changes in cancer diagnosis being a means of achieving this.

Proposed next steps

A permanent education and training for cancer committee or board, linking with the Pan London Early Detection and Awareness Board and the Living With and Beyond Cancer Board, would aid effective delivery of the strategy. It could also be the central point for sharing of resources and good practice. With representation from professional bodies and Health Education London it would have the credibility and resource to approach CCG's. Voluntary sector involvement with the committee is desirable. A systematic approach to training and education of all primary care staff could then be implemented across London. Many resources already exist or can be modified for application in the London context. By implementing the strategy, there is potential for developing sustainable change in practice.

The changes proposed can reach into secondary care. Employed staff are not always aware of cancer symptoms or benefits of screening. By using the established tools and encouraging sharing of knowledge with family and friends there is opportunity to spread this information.

The education and training committee would benefit from involvement from both integrated cancer systems. Working together to create a secondary and primary care education program would maximise resources. There is potential to continually assess the impact of particular interventions so giving an evidence base to the strategy.

A1 Education and training – secondary care

Addressing variation in workforce:

Access to Clinical Nurse Specialist (CNS) and Allied Health Professionals (AHP): - Evidence shows that patients are more likely to have a positive experience of care if they are supported by a cancer nurse specialist (CNS) in place, accessible, and available. CNSs and AHPs also have a central role in the delivery of cancer services and the care for the cancer patient (NHS Confederation 2010, Peer Review Annual Reports). The Patient Experience section of this strategy identifies a shortage of CNSs across London.

Work is required in partnership with Health Education England to understand how we can increase the numbers of CNSs across London. This may involve examining how opportunities for career progression can be made available.

Multi-disciplinary teams: Multi-disciplinary teams (MDT) are the core model for cancer service delivery in hospitals (Model of Care, 2010). Currently there is variability across London in structure, function, roles and compliance with IOG requirements of multidisciplinary team. The core structure and function of MDTs require review and a level of standardisation across London to ensure MDTs are effective vehicles to coordinate and deliver cancer services in provider organisations.

B. Research

There is a huge breadth and depth of existing expertise in cancer research across London, including three Academic Health Science Centres and the Institute of Cancer Research. The scope of research activity ranges from molecular biology work through to applied health services research

Evidence shows that patients who participate in clinical trials have improved outcomes. Currently there is wide variation in access to clinical trials at provider organisations across London. This is an opportunity to increase trial recruitment across the systems as well as creating an environment for research collaboration and implementation of research findings to improve services.

Increase access to new and innovative treatments:

The London cancer centres through their research programme and translational research are often at the forefront of developing and promoting innovative treatments. The Integrated Cancer Systems have a central role in promoting dissemination and uptake of evidence based innovative practice and ensuring equity of access for all appropriate patients.

It is recognised that research drives the quality of clinical care and therefore the Integrated Cancer Systems will maximise their potential for research across the system. It will be essential to promote the whole spectrum of research particularly focussing on health service research and translation of research into clinical practice and to support innovative models of service delivery.

Increase access to research:

At a national level clinical research has a high profile and the NHS constitution includes a duty to do research, "[...] through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population" (DH 2012).

There has been wide investment in a wide range of research into the causes of cancer, prevention, screening, diagnosis, therapy and the organisation and delivery of services. For example, investment in cancer research by the National Institute for Health Research (NIHR) has risen from £101 million in 2010/11 to £133 million in 2012/13. In addition there has been an increased focus through the National Awareness and Early Diagnosis Initiative (NAEDI) to develop high quality research projects in raising awareness and early detection of cancer. Currently there is wide variation in access of patients to research at provider organisations across London and both Integrated Cancer Systems are prioritising work to reduce variation. The scope for collaborative research across London is wide and ranges from basic sciences to health services research.

It will be crucial to develop robust communication across the London wide system, working across professional and organisational boundaries to ensure that the research skills and expertise available within cancer centres and other bodies, including patient groups, is brought to bear in improving cancer research across London. There must be the expectation that research is embedded within tumour specific and cross cutting pathway groups.

This work will require collaborative working with the other research stakeholders within London, for example CRNs, AHSNs, AHSCs and BRCs. Equally important will be developing a focus on the involvement of public, patients and families in the design and evaluation of cancer research wherever possible.

C. Commissioning

A key component of the implementation of the Transforming Cancer Services for London programme to date has been the effective use of commissioning and contracting processes to underpin the recommendations of clinicians and development teams across the capital. The use of the Commissioning Intentions and contractual levers and associated processes are described in the papers in Appendix three which were approved by the Cancer Commissioning Board on 9 December 2013. Commissioning Intentions (CIs) represent the means to communicate the Transforming Cancer Services for London (TCSL) programme's intentions for the following year, setting out how things will be different and the impact on providers. The Commissioning Intentions process ensures that resources are focused on realising the programme's mission and goals.

The publication of Commissioning Intentions in September represents the start of the process each year, allowing providers and other key stakeholders to be clear about the programme's intentions for the coming year. TCSL does not commission services directly from providers, so it is important to ensure that given the changes in the commissioning environment during 2012/13 and 2013/14 (the development of CCGs, Commissioning Support Units and the Cancer Transformation and Commissioning Teams), good lines of communication are maintained with these and all stakeholders.

The diagram at the back of the paper in Appendix three shows the approaches taken in the development of Commissioning Intentions for cancer and developing support for the recommendations. Following extensive discussions with commissioners across London appropriate governance has been set up to facilitate decision making and engagement across London. The three key elements of this are the pan-London Cancer User Partnership, Cancer Clinical Leadership Advisory Group and the Cancer Commissioning Board. These will remain key vehicles to ensure that the five year cancer commissioning strategy is fully implemented. A diagram of the strategic cancer commissioning governance for London is shown with summarised terms of reference in Appendix three.

D. Data and Information

Data and Information underpin every part of delivering the five year strategy for cancer. Cancer is fortunate to have seen an improvement in data available on services over the past 10 years, meaning there is now a wide range of data sources to assess the quality and outcome of services provided to patients. Much of this data is collected by providers in nationally agreed datasets and extracts of this data is used by CCGs and NHSE to support commissioning responsibilities.

1. National Cancer Registration Service (NCRS)

The National Cancer Registration Service (NCRS) is an England wide organisation which manages cancer registration, and is the successor organisation to the eight regional cancer registries. A broader range of cancer data is now flowing to the NCRS than the cancer registries traditionally collected. Hence it is important to consider how this new data source is accessed to track and benchmark progress in improving cancer outcomes and services in London. It should be noted that this is not the limit of data commissioners require to assure and assess services, for example cancer peer review and cancer patient experience surveys are not part of NCRS but are crucial data sources. Therefore an assessment of what other information, both currently routinely and not routinely collected is needed to effectively monitor progress in implementing the five year strategy.

The NCRS is operating using a single England-wide IT system (Encore). The NCRS will facilitate rapid processing of multiple local and all national data sources, using common standards and processes including data quality.

The NCRS also aims to provide rapid and direct feedback of data to clinical teams to enhance data quality and support for (near) real-time surveillance, cancer audit and analysis. The two ICSs have started discussions with the London NCRS team, in order to agree resources to analyse and report cancer information back to clinical teams. Both CCGs and NHSE will also benefit from access to NCRS data to support commissioning, although this is likely to be at a different level to the detailed data for clinical teams and work to understand this level of detail is now required.

The NCRS is still in its infancy and so accessing data may take some time to agree and so this should not be relied on in the short term. However it is important to establish mechanisms to access this data both for the ICSs and commissioners in London.

2. Existing Data Collected by Providers

As referred to above providers are already required to collect a range of national datasets associated with cancer, and that these provide a wealth of information to track progress in improving cancer services in London.

- I. Cancer Outcomes and Services Dataset – via the NCRS (MDT, pathology, PAS data)
- II. National Cancer Waiting Times monitoring dataset
- III. National Cancer Experience Survey
- IV. Diagnostic Imaging dataset
- V. National Clinical Audits (Bowel, Lung, Head and Neck, Oesophago-gastric)
- VI. Radiotherapy dataset – radiotherapy providers
- VII. Systemic Anti-Cancer Therapy dataset
- VIII. Breast Screening – screening providers only
- IX. Cervical Screening – screening providers only
- X. Bowel Screening - screening providers only

3. Additional Data Required from Providers

Within the commissioning intentions for 2014/15 providers in London are required to provide additional information in the following areas in order to track progress against quality requirements. These are listed below. Given the range of data providers already have to collect it is recommended that further data requests are avoided if possible.

- I. Waiting times and reporting turnaround times for Colonoscopy and Flexible Sigmoidoscopy Tests (other tests reported via DID dataset).
- II. Monitoring of the numbers of cancer patients having Holistic Needs Assessment and Care Plan
- III. Monitoring of the numbers of cancer patients having Treatment Summary
- IV. Monitoring of the numbers of cancer patients having Health and well-being event
- V. Numbers of follow-up appointments for Breast, Colorectal and Prostate patients (Stratified Pathways)
- VI. Source of referral for every cancer patient having first treatment to enable tracking of emergency presentations of cancer.
- VII. Breach reports for all patients breaching the 62 day target must be recorded on the cancer waits system on Open Exeter in line with standardised approach outlined in information requirements.
- VIII. The trust should summarise 100 day breaches of cancer waits
- IX. Trusts are required to provide hospital site performance for all cancer waits targets.

4. Standardised CCG and Trust Level Benchmarking Report within London

During 2013/14 London set out a core of key cancer commissioning metrics on cancer services; with the development of the five year cancer commissioning strategy for London it is logical to extend this set of indicators to incorporate metrics to measure the implementation of the five year strategy. Within the working draft of the cancer commissioning strategy for London there are 52 proposed interventions and further work is required to enable measurement of these. Work during the first part of 2014/15 will be undertaken to define what these are and whether further indicators need to be incorporated into the Information Schedule moving forwards.

Within London there are experts in cancer information and data both within the two ICSs and within the new TCST. Each of these teams produce a range of reports already, for example London Cancer produces a series of reports for its pathway boards, the London Cancer Alliance produce a regular report against the commissioning metrics and the NELCSU have recently developed a benchmarking report against the commissioning metrics.

Agreeing a single standardised format for a CCG and Trust level benchmarking report would be an important step in terms of reducing variation across all of London. This has to be balanced with the challenge of benchmarking a large number of providers and CCGs in London and reflecting the two cancer systems in such a report.

5. Concluding thoughts

Considerable time and energy has been invested into developing the five year cancer commissioning strategy and being able to measure progress against implementation and to ensure an improvement on cancer outcomes and patient experience is clearly crucial. As identified above, further work is required to identify how to measure and baseline each of the interventions described in the strategy and how progress will be tracked over time.

In order achieve this and to develop a standardised benchmarking report as outlined above, will require close collaborative working between the new Transforming Cancer Services Team, the ICSs, Public Health England with access to NCRS as well as with NHSE and CCGs.

E. 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.

Appendix one: 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				

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				
Breast - immediate breast reconstruction				
Breast - metastatic management				
Breast – timely/ equitable access				
Lung - resection rates				
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
Sterotactic 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				

Appendix 1: A report of the CCG engagement events held in November 2013

1 Objective of this document.

The objective of this document is to:-

- (a) Set out the process used to develop the CCG engagement events held in November 2013;
- (b) Document the outputs from the process.

2 Background.

During the summer and autumn 2012, a series of five CCG engagement events were held across London. Engagement events were focused around geographical locations (and the five sector GP cancer leads who support the Programme and are also part of the cancer Commissioning Board - CCB). Planning was focused on delivering an engagement event in each of the NW, NC, NE, SE and SW London sectors.

The results of this process were written up and shared with the Cancer Commissioning Board, as well as sector GP cancer leads.

3 Process.

During summer 2013, the decision was made to repeat the CCG engagement events that had been run during 2012, to:-

- inform the five-year planning process that was being developed;
- link with *A call to action*
- share plans being considered for implementation in 2014/15

Planning by the Transforming Cancer Services for London (TCSL) programme team started in August 2013, with dates being agreed with each of the five sector GP cancer leads, as it was important that they led the process within their geographical patch. Dates were set for November 2013, with invitations being co-ordinated with each sector GP cancer lead.

Each event was supported by the TCSL programme team, with Paul Roche and Paul Chiles supporting all five events and Denise Bailey and Cerrie Baines also supporting some events.

A set of slides was developed, covering each of the sections to be covered; as this was 55 slides, this was then split into two slide packs, with the first being used as the agenda and content to be handed out to each attendee and the second being held in reserve, as more detailed slides in certain areas, and handed to attendees at the appropriate point in the event when the content was required.

Each event started with an introduction section from the sector GP lead, setting out the background to the evenings event, covering:-

- Case for Change 2009
- Model of Care 2010
- Key messages from the CCG engagement events 2012

- *A call to action*
- Development of six key priority areas for 2013/14 onwards

The discussion was then structured into the following sections:-

1. Early Detection and Population Awareness.
2. Cancer screening.
3. Living with and beyond cancer.
4. Improving communications with primary care.
5. Reducing variation in secondary care.

For each section, a few introductory slides were presented, to focus the discussion, with the key questions being set for each area:-

- In which of these areas would implementation make the biggest difference for you?
- Are there priorities/areas not included that you would like to see included?

At the end of the evening, there was an opportunity to pick up any areas that had not been covered already.

The findings from each event were fed in, as appropriate, to the following events so that a composite picture could be developed and new insights/considerations tested with other attendees.

The findings from the five events were collated into this document and the results are shown in the following sections.

4 Findings.

The findings from the five events were collated and used in a variety of ways, including:-

- informing the development of the five-year strategic plan
- providing input into the *A call to action* process
- developing quality indicators for 2014/15 contracting round

The findings are detailed in the following sections.

4.1 Early Detection and Population Awareness.

A series of recommendations were contained within the slide pack taken to the engagement events and each is discussed below. In discussion the following key points were made:-

4.1.1 Initiatives to drive up the early diagnosis of prostate cancer.

It was proposed that prostate cancer should not feature as a priority in the ED&PA workstream, as it was felt that there was not a strong enough evidence base to be able to justify this as a priority. Comments were made including:-

"most people die with it, not die of it"

"why is prostate cancer included in here? realistically, what can you do about it?"

Therefore it was agreed that initiatives focused on driving up the early diagnosis of prostate cancer should NOT be a priority.

4.1.2 Initiatives to drive up the early diagnosis of colorectal cancer.

This was agreed to be a priority area.

4.1.3 Initiatives to drive up the early diagnosis of upper GI cancer.

This was agreed to be a priority area.

4.1.4 Initiatives to drive up the early diagnosis of lung cancer.

This was agreed to be a priority area.

4.1.5 Improving GP referrals through Practice profile work.

This was an area where there was a great deal of support for focused facilitated sessions in practices, linked to a well-structured GP education programme. This was felt to be key to assisting practices to develop plans to improve early detection work. GP education and work to implement cancer decision support tools in all practices was also raised.

4.1.6 Reducing system delays by increasing endoscopy capacity.

The commissioning of increased capacity for lower GI endoscopy, both flexi-sigmoidoscopy and colonoscopy, was felt to be a key priority. This is already proposed as part of Commissioning Intentions for 2014/15.

4.1.7 Implementing RCGP/RCR suggested response times for GP diagnostics.

Implementing these suggested response times was universally recommended. The suggestion that the proposed response times be included in all secondary care provider contracts for 2014/15 was welcomed. This should also be combined with an increase in the quality of clinical information received from hospitals.

4.1.8 Additional areas proposed for consideration.

- Initiatives to drive up the earlier diagnosis of cervix and breast cancer
- GP direct-access gastroscopy, within two weeks
- Building on national awareness work
- Increasing the availability of data and its usage

4.2 Cancer screening.

The three national screening programmes were one area where there was a great deal of discussion, as the general feeling was that the national programmes are not well co-ordinated and a number of small changes could be introduced to improve both the coverage and uptake, particularly of the breast and bowel screening programmes. In Birmingham, Community Activists are used as part of the screening programmes.

There were felt to be a number of common solutions that could be introduced and that the programmes needed to be flexible enough to be tailored to the specific needs of sub-boroughs.

It was felt that if there was a greater sharing of data with practices, particularly when patients had not taken up the screening offer, practices could ask patients why and seek to increase the uptake rate. The fact that letters were not sent out in languages appropriate to the local population was felt to be a major omission. There is a need to make all letters (in whichever language they are written) far more user-friendly.

A number of questions were raised in a general discussion about the effectiveness of the national screening programmes, including:-

- Why are GPs unable to book people in for a mammography?
- Why are GPs unable to have a supply of FoBT kits in their practices and, when required, be able to explain how to use it?
- Why are letters not written in ways that are suitable for people whose first language is not English, or that letters can be links to video clips etc. that would be suitable for people with learning disabilities?
- If letters look like they can from the GP; there was felt to be a greater possibility of increasing the uptake rate.
- Can GPs be given lists so that they know which of their patients are being invited?
- Can screening be linked to long term disease management programmes?
- How can outlier practices be targeted?
- How can screening be linked to the development of community champions (such as with the Diabetes Champion programme)?
- Could there be a one-off flexi-sigmoidoscopy at 55 years old, with feedback to practices about how many cancers are detected via this initiative?

The issue of the programmes being commissioned by NHS England (as opposed to CCGs) was raised, as was the fact that the recall method was different for each of the three national programmes.

4.2.1 Improving coverage and uptake - breast screening.

This was agreed to be a priority area.

4.2.2 Improving coverage and uptake - cervical screening.

Of the three national screening programmes, this was felt to work best because the focus was on using practice lists and this fed through into the high uptake rate.

4.2.3 Improving coverage and uptake - bowel screening.

This was agreed to be a priority area, though it is the national programme that was felt to be working the least well. Practices were undertaking a number of work-arounds to support the programme, but were frustrated by the fact that they could not, for instance, take the opportunity to discuss the screening and hand out a kit to patients when there were in the surgery.

The current FoBT system was compared with the FIT system being used in many other countries and the fact that, in Canada, a GP-led FIT programme had an 80% uptake rate.

4.2.4 Implementing planned age extensions.

It was felt that although these were being introduced, their implementation could actually lead to a lower uptake.

4.2.5 Reducing variation in primary care.

There was felt to be a great degree of variation in primary care across quite small geographical areas which needed to be tackled.

4.2.6 Improving population awareness and community engagement.

There was not felt to be enough clarity on what was the national screening offer, with a greater need to create patient demand for the programmes, creating a greater population awareness.

4.2.7 Data-sharing in place between hubs and practices.

This is an important issue that was not well-understood by practices. For hubs to be able to share data electronically with practices, practices have to request this from the hub; it is not possible for the hub to send data to practices automatically. The desire is also for data to be coded in such a way to be able to be added into practice systems.

There was a request that hubs share uptake by practices with each CCGs Primary Care Cancer Lead.

4.2.8 Additional areas proposed for consideration.

- Stronger Public Health approach to screening and links with what is happening, in terms of coverage and uptake.

4.3 Reducing variation in secondary care services.

4.3.1 Model of Care recommendations.

Progress with delivering these should be published, with JAG accreditation being included, so that CCGs could be clear about which providers provided JAG-accredited services and which did not. This could then be used to influence their commissioning decisions.

4.3.2 Best Practice Commissioning Pathways.

Direct access colonoscopy for GPs, via a triage process, was felt to be important.

4.3.3 Provider implementation of Clinical Guidelines.

Length of stay variation should be published.

4.3.4 Acute Oncology Services.

Peer Review outcomes should also be shared with commissioners, so that CCGs could be engaged in the improvement process.

The development of an effective AOS was key to many of the issues associated with delivering effective urgent care services. An effective AOS would lead to a better diagnosis, with patients being routed into the correct part of the service. The Chelsea and Westminster AOS has led to an increased patient experience and a reduction in bed-days.

Admission avoidance was seen to be a key result area for the AOS, so that the AOS should be a seven day service.

Knowledge of the main contacts in each AOS was important, with data on CCG websites, so that GPs knew who exactly to contact.

4.3.5 Publication of data.

The publication of data on areas of variation should be encouraged.

4.3.6 Treatment near the end of life.

Treatment near the end of life was felt to be an important issue, with issues around death within 30 days of receiving chemotherapy being an issue raised by NCEPOD. Coupled to this was the fact that communication about second and third courses of palliative chemotherapy was not always highlighted as such, or whether the chemotherapy was proposed as curative or palliative.

4.3.7 Additional areas proposed for consideration.

- Joint education of primary and secondary care clinical staff.
- Chemotherapy usage - patients who start a course of chemotherapy but do not complete it.

4.4 Living with and beyond cancer.

One of the common themes through each of the events was for letters etc. from secondary care to be written in such a way that the patient and the GP both understood the contents. It was felt that they were written in a secondary care 'jargon', which many GPs (and most patients) found impenetrable.

4.4.1 Holistic Needs Assessment.

It was felt that this should not just a snap-shot, but be followed up to ensure it is implemented. It should also include an assessment of psychological support required.

4.4.2 Providing a Care Plan.

No further specific comments.

4.4.3 Providing a Treatment Summary.

This should be standardised, as per the NCSI document, compared with regular communication through updates from secondary care. This should not include READ codes.

4.4.4 Enhancing the primary care Cancer Care Review.

This was already changing, with a move from being a one-off event to being an ongoing review (similar to a diabetic or asthma review). The feeling was that a six month timescale was probably too short and that it was important to ask patients what they actually wanted.

4.4.5 Developing a health and well-being event.

There were examples already in place in London, but learning from the Expert Patient Programme should also be taken into account. Such transition events could possibly be developed as a health-led first event, with social-led subsequent events, including links into existing local authority projects and programmes.

There were deeply divided views about whether this should be:-

- definitely run by secondary care
- definitely run by primary/community care

and it was recognised that a variety of approaches should be tested, to develop two/three proposed approaches to be implemented in future years.

4.4.6 Tackling the Consequences of Treatment.

No further specific comments.

4.4.7 Developing enhanced patient experience measures.

No further specific comments.

4.4.8 Additional areas proposed for consideration.

- Implementation of stratified pathways for follow-up, with the greatly reduced need for multiple follow-up outpatient appointments. This would also support the transfer of

routine care from secondary to primary care settings, with open-access follow-up, if required.

- Back to work assessment.
- Financial assessment.
- Flagging patients in GP systems when people are receiving active chemotherapy.
- Ditto treatment beyond the Treatment Summary (e.g. herceptin), also highlighted in the secondary care letter.
- Existing activities within the CCG being opened to cancer patients (e.g. exercise programme linked to LTC).

4.5 Improving communications with primary care.

4.5.1 Access to data from hospital systems.

This was felt to be important for care planning, not just for results, though access to pathology and radiology results were both felt to be important developments.

There was a focus on finally having primary care access to data from secondary care settings, something which was felt to have been discussed and promised for many years. This could be something that would be written into secondary care provider contracts and undertaken as a proper programme of works. Such as development, through the use of a CQUIN, had been put in place in NWL for the 2012/13 and 2013/14 years, with significant financial resources been allocated to the CQUIN to deliver this.

4.5.2 Letters written in appropriate language.

Letters needed to be language-appropriate and that could be understood both by the patient and their GP. The lack of this could mean that when the patient visited their GP, the GP was unable to advise and could often end up referring the patient back to hospital.

Letters would also be appreciated in a standard format, with clarity on what GPs were expected to do with this information, appropriately coded. An indication of the prognosis and how treatment could be impacting on the patient's life would be appreciated.

4.5.3 Co-ordinate my Care.

Although a cloud-based system, *Co-ordinate my Care* was felt to be a "nightmare" system, with people having great difficulty with logging in and the consents needed to view records.

4.5.4 Appropriate handover.

The lack of an appropriate handover (from secondary to primary care) was also highlighted as an issue (which also links to the Treatment Summary - see 4.4.3).

5 Conclusions.

Prior to the CCG engagement events, the set of slides was developed with content dealing with each of the main areas covered in the previous section. The main reflections on the events can be split into the following areas:-

5.1 Content.

The content that was developed for the 2013 engagement events was drawn from the Programme workstreams and the emerging five-year strategic planning activities that were being developed in parallel.

The reflections from the engagement events were that, with one or two specific anomalies, the content was accepted by attendees as representing a composite picture of the key areas for development. The two specific anomalies were:-

- **Early detection of prostate cancer** - where it was universally rejected as a priority, with substitution of other cancers instead, for early detection work.

This is within the gift of the London-wide Programme to change and has already been taken into account in planning early detection work in 2014/15 and beyond.

- **Cancer screening** - where the operation and management of the three national screening programmes were targeted as an area where there was considerable scope for improvement. This included seeking to influence the ways in which the programmes were run, at both a national and London-wide level.

This second area is worthy of a wider dialogue, both within London and with those who run the national screening programmes. It is accepted wisdom that 'changes cannot take place because they are national programmes', whereas the strong views being expressed through the 2013 engagement events were that there are specific, but important, changes that could be introduced, within the framework of the national programmes that it was felt would deliver greater improvements and benefits than what was already on offer.

It is hoped that such a dialogue may take place, both within London and with the national programmes, to explore the possibilities of introducing improvements to these national programmes, within the context of running national programmes.

Appendix A – Event attendees.

Primary Care and Prevention Board for NE and NC London – 5th November

Attendees:	Role:	Organisation:
Clare Stephens	GP, Primary Care Cancer Lead	Barnet CCG
Julia Ozdilli	Early Detection Lead	N&E CCT
Paul Roche	Programme Director	TCSL, NHS England
Paul Chiles	Programme Manager	TCSL, NHS England
Lance Saker	GP	Camden CCG
Karen Sennett	GP	Islington CCG
Kathy Pritchard-Jones	Programme Director	London Cancer
Liz Bates	Primary Care Engagement Programme Lead	CR:UK
Alex Tran	Primary Care Cancer Lead for NE London	Havering CCG
Dr Zuhair Zarifa	Chairman	Newham CCG Board
Maggie Luck	Population Health Practitioner Lead (N&EL)	NHS England
Dr Mike Gocman	Cancer Lead	Enfield CCG
Dr Karen Sennett	Cancer Lead	Islington CCG
Nikki Cannon	Senior Macmillan Development Manager	Macmillan
Dr. Philip Abiola	Cancer Lead	Newham CCG
Lucia Grun	Cancer Lead	Camden CCG
William Roberts	Director of Strategy & Planning	Camden CCG
Jennifer Layburn	Programme Director at North East London Cancer Network	NE&NC CCT
Dr Alpesh Patel	Chairman	Enfield CCG
Andy McMeeking	Cancer Commissioning Team Manager	NE&NC CCT

NE London – 12th November

Attendees:	Role:	Organisation:
Alex Tran	Primary Care Cancer Lead for NE London	Havering CCG
Paul Roche	Programme Director	TCSL, NHS England
Paul Chiles	Programme Manager	TCSL, NHS England
Andy McMeeking	Cancer Commissioning Team Manager	NE&NC CCT
Gulsen Gungor	Senior Locality Lead	Redbridge CCG
Jyoti Sood	Clinical Director, GP	Redbridge CCG
Archna Mathur	Deputy Director for Quality and Performance	TH CCG
Layla Theiner	CR:UK facilitator	CR:UK
Daniel Callanan	Macmillan facilitator	Macmillan
Sarah D'Souza	Senior Locality lead, Planning and Integation	B&D CCG
Sharon Morrow	Operating Officer	B&D CCG
Chloe Atkinson	Business Delivery Manager	West Essex
Tony Lawlor	Commissioning Manager	NE&NC CCT
Alan Steward	COO	Havering CCG
Dr Maurice Sanomi	GP	Havering CCG
Dr Waseem Mohi	Chair	B&D CCG
Cerrie Baines	Programme Support Officer	TCSL, NHS England
Kate Kavanagh	Cancer Commissioning Manager (BHR & West Essex)	NE&NC CCT
Dr Munesh Mistry	Cancer Lead, GP	Waltham Forest CCG

SE London – 19th November

Attendees:	Role:	Organisation:
Paul Roche	Programme Director	TCSL, NHS England
Paul Chiles	Programme Manager	TCSL, NHS England
Cathy Burton	Primary Care Cancer Lead	W&SCCT
Denise Bailey	Programme Support Officer	TCSL, NHS England
Charles O'Hanlon	AD for Transformation and Redesign	Bexley CCG
Shelley Dolan	Chief Nurse	LCA
Kate Haire	Consultant in Public Health Medicine	LCA
Liz Clegg	Assistant Director Older People and Client Groups	Lambeth CCG
Anthony Cunliffe	Cancer Commissioning Lead	Wandsworth CCG
Dr Faruk Majid (Board member)	Cancer Lead (Board member)	Lewisham CCG
Neil Stephenson	Assistant Director Acute	CSU
Isatta Lamboi	Cancer Lead	Bromley CCG
Katrina McCormick	Deputy Director Of Public Health	Lewisham
Kate Moriarty-Baker	Head of Continuing Care & Safeguarding Client Group Commissioning	Southwark CCG
Dr Emily Gibbs	Cancer Lead	Southwark CCG
Dr Adam Bradford	Cancer Lead	Southwark CCG
Dr Tamsin Hooton	Clinical Lead	Southwark CCG
Liz Bates	GP Engagement Lead	CR:UK
Dr Ram Aggarwal	Cancer and EOL Lead	Greenwich CCG
Maha Saeed	PH Lead	Hounslow CCG
Donal Gallagher	Macmillan Facilitator	Macmillan
Barbara Gallagher	User Involvement Lead	W&SCCT
Sarah Deedat	Public Health for Adults	Wandsworth

SW London – 20th November

Attendees:	Role:	Organisation:
Tony Brzezicki	Primary Care Cancer Lead	Croydon CCG
Paul Roche	Programme Director	TCSL, NHS England
Paul Chiles	Programme Manager	TCSL, NHS England
Kate Haire	Consultant in Public Health Medicine	LCA
Catherine Millington Sanders	GP, Cancer Lead	Richmond CCG
Livia Royle	Consultant in Public Health & Educational Supervisor	Kingston CCG
Dan Hughes-Morgan	CR:UK facilitator	CR:UK
Catrina Charlton	Commissioning Manager	Merton CCG
Mark Wells	GP, Wrythe Green Surgery	Sutton CCG
Maria Adeeko	Service Improvement Project Manager	W&S CCT
Cerrie Baines	Programme Support Officer	TCSL, NHS England

NW London – 28th November

Attendees:	Role:	Organisation:
Dr Pawan Randev	Primary Care Cancer Lead	W&SCCT
Paul Roche	Programme Director	TCSL, NHS England
Paul Chiles	Programme Manager	TCSL, NHS England
Vijay Tailor	GP Partner, Hillcrest Surgery, W3 9RA	Ealing CCG
Heschil Lewin	Cancer Lead	Harrow CCG
Dr Afsana Safa	Cancer Lead	Central London CCG
Sue Pascoe	Chief Operating Officer	Ealing CCG
Katy Saunders	Facilitator	Macmillan
Sarah Gigg	Senior Macmillan Development Manager, West & South London	Macmillan
Susan McGoldrick	GP	Hammersmith & Fulham
Anindita Debnath	Senior Strategy Implementation Manager	Hounslow CCG
Cerrie Baines	Programme Support Officer	TCSL, NHS England
Kate Haire	Consultant in Public Health Medicine	LCA

Appendix 2: Developing cancer Commissioning Intentions for 2014/15

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6 Objective of this document.

The objective of this document is to:-

- (c) Set out the process and engagement that has been used to create cancer Commissioning Intentions for 2014/15;
- (d) Document the content of the draft Commissioning Intentions for 2014/15.

7 Background.

Commissioning Intentions (CIs) represent the means to communicate the Transforming Cancer Services for London (TCSL) programme's intentions for the following year, setting out how things will be different and the impact on providers. The Commissioning Intentions process ensures that resources are focused on realising the Programme's mission and goals.

The publication of Commissioning Intentions in September represents the start of the process for 2014/15, allowing providers and other key stakeholders to be clear about the Programme's intentions for the coming year. TCSL does not commission services directly from providers, so it is important to ensure that given the changes in the commissioning environment during 2012/13 and 2013/14 (the development of CCGs, Commissioning Support Units and Cancer Commissioning Teams), good lines of communication are maintained with these and all stakeholders.

8 Process.

8.1 Context.

The TCSL programme workstreams developed and collated a set of draft Commissioning Intentions for 2014/15 that have been discussed with London CCGs and discussed and endorsed by the Cancer Commissioning Board at its meeting on 23rd September 2013. The diagram in appendix E shows this process.

Draft cancer CIs have been communicated to providers and to the commissioners who will lead the contracting round 2014/15 (i.e. a combination of existing acute and specialist contracting teams, CCGs, screening commissioners, primary care commissioners and Cancer Commissioning Teams - CCTs).

This arms-length commissioning approach is more complex than for standard acute commissioning and, combined with the changes in the commissioning environment, heightens the need for both the timetable and the resulting Commissioning Intentions to be well-communicated and very clear, so that there is no confusion (or breakdown in the process) between creation and implementation.

8.2 April to September 2013.

The Programme's Cancer Programme Executive (CPE) in July received a brief update, highlighting the headlines that were being considered. During July and August, Programme workstreams developed their draft Commissioning Intentions. At the same time, both CCTs were meeting up and discussing draft CIs with local CCGs, to gain their understanding and support for them. The output from these twin-track processes has been fed into this report.

The CPE in August discussed progress with the development of Commissioning Intentions from each workstream, with a collated version of the draft Commissioning Intentions being prepared for discussion by the Cancer Clinical Leadership Advisory Group (CCLAG) and endorsement by the Cancer Commissioning Board (CCB) at their meetings during September.

Both CCTs have taken a lead in discussing draft cancer Commissioning Intentions with London CCGs within their patch; this has been undertaken in a variety of ways, to ensure optimal engagement and buy-in.

8.3 October to December 2013.

Following endorsement by the Cancer Commissioning Board in September 2013, the draft CIs were issued to all key stakeholders and discussed. At the same time, workstreams continued to work on their draft CIs and refine the detail, leading to the production of this final CI document.

During November 2013, a series of CCG engagement events were held and, while these were aimed at supporting the five year strategic planning work, they were also used to test and refine aspects of the draft CIs with the circa 40 GPs and 40 other CCG and cancer representatives who attended the five sessions. There was contact with 28 of the 32 London CCGs through this process alone.

The final CI document is now being presented to the Cancer Commissioning Board for endorsement at their meeting in December 2013.

Following this meeting, the final CIs will be issued to all key stakeholders. Meetings are being set up with each Commissioning Support Unit (CSU), to discuss the cancer CIs (and associated documentation - Quality Requirements, Information Requirements etc.) to ensure they are well understood and are included in contract documentation for 2014/15.

8.4 January to March 2014.

In January/February 2014, each contracting teams will negotiate the cancer content (as part of their negotiation of the whole provider contract), with the expected DH timetable being that all contracts will be agreed and all contract documentation completed by 31st March 2014.

9 Timetable.

The timetable has been set out to include the key milestones that need to be met, in order to deliver cancer CIs within the required commissioning timetable. The detailed timetable is shown in Appendix A.

10 Engagement with key stakeholders.

The engagement of key commissioners – CCGs and specialist commissioning, screening commissioners, primary care commissioners – in the process of developing the draft CIs for 2014/15 has been key. With the changes in the commissioning of services over the past 18 months, it has become increasingly difficult to gain the necessary clarity on the process(es) needed to be followed to assure key commissioner support. The detail is contained in appendix C.

Following endorsement in September 2013, the draft Commissioning Intentions were circulated to all key stakeholders, including:-

- London CCGs
- Integrated Cancer Systems
- London Commissioning Support Units (who will be leading the acute contracting round 2014/15, working on behalf of their local CCGs)
- NHS England:-
 - specialist commissioning
 - screening commissioning
 - primary care commissioning

11 Draft Commissioning Intentions.

The development of CIs has been considered with the following categorisation, closely following the patient pathway:-

- Early Detection and Population Awareness
- Reducing variation
- Living with and beyond cancer

The focus for 2014/15 is to consolidate the significant progress made in 2013/14 and to build on the three key areas listed above.

11.1 Early Detection and Population Awareness.

- The continued support for population awareness
- Improvement in cancer screening coverage and uptake
- National screening programmes – delivering the age extensions
- The implementation of Early Detection Best Practice Commissioning Pathways for:-
 - Lung

- Colorectal
- Ovarian
- The implementation of the lower GI endoscopy commissioning strategy
- Improve GP direct-access diagnostic turnaround times

11.2 Reducing variation (along the pathway).

- Reduction of variation between providers and within providers
- Consolidation of specialist services
- Implementation of *Co-ordinate my Care* on a consistent basis across London
- Implementation of national specialist commissioning service specifications
- Implementation of a radiotherapy commissioning strategy
- Implementation of a chemotherapy commissioning strategy

11.3 Living with and beyond cancer.

- The implementation of the living with and beyond cancer elements of the Best Practice Commissioning Pathways
- The extension of the Recovery Package:-
 - Increasing the number and percentage of people who complete a Holistic Needs Assessment
 - Increasing the number of people with a Care Plan and Treatment Summary
 - developing the use of a Health and well-being event
- Sustaining recovery
- Focused patient experience measures
- Restructuring of the Cancer Care Review
- Implementing defined quality improvement metrics associated with consequences of treatment
- Implementation of stratified pathways
- Supporting people with active and advanced disease

The CIs are shown in more detail in Appendix B.

12 Financial implications.

The financial implications of each draft CI have been considered, with the implementation of the endoscopy commissioning strategy being the CI where there is the greatest financial consequence for CCGs that cannot be contained from within existing resources (substitution of activities/opportunity cost). The initial assessment is that other CIs are considered to be able to be delivered from within resources already allocated to cancer services, though the impact of implementing the specialist commissioning service specifications is being considered.

The tension in the system about this issue cannot be underestimated, as feedback from workstreams and CCTs is that while some CCGs are content to invest in key areas, improving cancer services, some CCGs are actively seeking to disinvest in cancer services. Such

tensions mean that it is not going to be possible to achieve agreement among all 32 CCGs for the implementation of the cancer Commissioning Intentions.

This leads to a dilemma about how changes which only work on a London-wide basis (such as changes associated with GP direct access endoscopy) can be implemented in an effective way.

13 The use of contractual levers.

It is important that all contractual levers that are available through the NHS standard contract are considered when developing CIs, as different contractual levers can be used to deliver service improvement.

The success in delivering a focused and co-ordinated set of contractual levers into the 2013/14 contract documentation shows that it is possible to deliver service improvement through the use of contractual levers.

Some contractual levers have different consequences when used, so adopting the correct lever is important (see Appendix D).

Appendix A – Commissioning Intentions timetable for 2014/15

ID	Icon	% Complete	Task Name	Duration	Start	Finish	Predecessors	Timeline																	
								2012		Qtr 1, 2013			Qtr 2, 2013			Qtr 3, 2013			Qtr 4, 2013			Qtr 1, 2014			
								Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
202		1%	Commissioning cycle 2014/15	265 days	Mon 25/02/13	Fri 28/02/14																			
203	✓	100%	Development of outline timetable for 2014/15 commissioning	3 days	Mon 25/02/13	Wed 27/02/13																			
204	✓	100%	Sign-off for outline timetable at CPE	0 days	Tue 23/04/13	Tue 23/04/13	203																		
205		0%	Sharing outline timetable with keystakeholders	0 days	Thu 25/04/13	Thu 25/04/13	204FS																		
206		0%	Commissioning cycle implementation	224 days	Tue 23/04/13	Fri 28/02/14																			
207		0%	Development of draft CIs byworkstreams	30 days	Fri 26/04/13	Thu 06/06/13	205																		
208		0%	Engagement with CCGs to develop draft CIs	30 days	Fri 26/04/13	Thu 06/06/13	205																		
209		0%	Discussions with London Clinical Commissioning Council	30 days	Tue 23/04/13	Mon 03/06/13	204																		
210	📅	0%	Review of draft CIs at CCLAG	0 days	Thu 06/06/13	Thu 06/06/13	207,208																		
211	📅	0%	Review of draft CIs at CCB	0 days	Wed 03/07/13	Wed 03/07/13	210																		
212		0%	Development of draft CIs byworkstreams	47 days	Wed 03/07/13	Thu 05/09/13	211																		
213		0%	Engagement with CCGs to develop/encourage support for draft CIs	47 days	Wed 03/07/13	Thu 05/09/13	211																		
214		0%	Discussions with London Clinical Commissioning Council	47 days	Wed 03/07/13	Thu 05/09/13	211																		
215	📅	0%	Review of draft CIs at CCLAG	0 days	Thu 05/09/13	Thu 05/09/13	212,213																		
216	📅	0%	Review of draft CIs at CCB	0 days	Mon 30/09/13	Mon 30/09/13	215																		
217		0%	Engagement with/support for CCGs	45 days	Mon 30/09/13	Fri 29/11/13	216																		
218		0%	Discussions with London Clinical Commissioning Council	45 days	Mon 30/09/13	Fri 29/11/13	216																		
219	📅	0%	Review of draft CIs at CCLAG	0 days	Thu 05/12/13	Thu 05/12/13	217,218																		
220	📅	0%	Sign-off of draft CIs at CCB	0 days	Mon 09/12/13	Mon 09/12/13	217,219																		
221		0%	Inclusion of draft CIs in contract negotiations	60 days	Mon 09/12/13	Fri 28/02/14	220																		

Appendix B – Draft Commissioning Intentions.

(A) Early Detection and Population Awareness.

The continued support for population awareness

London's 'Get to know cancer' pop-up shops and the recruitment of Cancer Activists are proving to be an effective way of increasing public awareness of issues relating to cancer. Further pop-up shops are proposed for 2014/15, subject to funding being made available by the relevant local authority or CCG. The national 'Be Clear on Cancer' campaign highlights the signs and symptoms of specific cancer, with a continued support and dissemination of campaign information (this will include asking practices to put up posters etc. and support the evaluation of the campaign).

Revenue funding for pop-up shops would be provided by individual CCGs or councils.

The implementation of Early Detection Best Practice Commissioning Pathways

Early Detection pathways have been developed for lung, colorectal and ovarian cancer and these will be included, with the living with and beyond cancer pathway elements, in the revised Best Practice Commissioning Pathways. These will be included as service specifications within the 2014/15 contracts. The main recommendations are:-

Ovarian pathway:-

1. Undertake both CA125 and trans-vaginal ultrasound concurrently.
2. Ensure GPs consider referral along colorectal pathway.

Colorectal pathway:-

1. Commission direct access to one stop diagnostic service in secondary care.
2. Reduce the threshold age for referring new onset colorectal symptoms from 60 years of age in 2013-14 to 55 in 2014-15 and 45 in 2015.

Lung pathway:-

1. All primary & secondary care staff trained in giving Very Brief Advice in smoking cessation.
2. Develop excellent links with local stop smoking services.
3. Ensure safety-netting processes in place to ensure patients, where appropriate, are recalled for chest X-ray.
4. Ensure a CT scan is undertaken in advance and that the report is available when a patient attends an outpatient clinic appointment.
5. Whenever a chest X-ray takes place, ensure it is reported.

Revenue funding for the implementation of the early detection pathways would be from CCGs, through additional activity at individual secondary care providers.

Improvement in cancer screening coverage and uptake

The improvement of cancer screening coverage and uptake, for London, through implementation of a number of specific intentions, including:-

- Reconfiguration of cervical screening
- Roll-out of changes associated with HPV testing
- Centralisation of breast screening administration
- A defined set of measures/metrics

Revenue funding for improving cancer screening uptake would be provided from NHS England, through the national screening programmes, with funding for active treatment generated through improving screening uptake being funded by CCGs, through their contracts with secondary care acute providers (patients who remain in the surveillance programme are funded via the national screening programmes).

National screening programmes – delivering the age extensions

There are age extensions to be implemented for national screening programmes, including breast screening, bowel (for SE and NE London, as this has not yet been rolled-out) and familial history – patients at high risk; details held by screening commissioning.

Revenue funding for age extensions of the national screening programmes would be provided from NHS England, through the national screening programmes.

The implementation of the lower GI endoscopy commissioning strategy

An evidence-based strategy has been developed to provide the case for each CCG, highlighting the difference between the level of services currently being commissioned and what is proposed for 2014/15 and beyond. The main recommendations are:-

1. Commission only from JAG accredited provider whether NHS or private.
2. Commission additional endoscopies as per the early detection best practice commissioning pathway for colorectal cancer.
3. Barium enema is obsolete as a first-line diagnostic test and should not be used for this purpose.
4. Ensure surveillance approach for symptomatic patients means all patients are recalled appropriately with no patient at risk of falling through the gap.

Revenue funding would be provided by CCGs, through their contracts with secondary care acute providers. An assessment of the additional activity required, by CCG, has been estimated and this will be shared with each CCG.

GP direct-access diagnostic turnaround times

Some CCGs are requesting that the College of Radiology guidance on turnaround times is included in contracts for 2014/15. This has been debated with CCGs, during October and November, gaining

wide-spread support for their inclusion. The practicalities have been worked through the Programme's contracting workstream and have been included as a quality indicator.

Cancer outcomes by MDT

The provision of cancer outcomes by MDT is being requested by some CCGs; details being worked through, though this is likely to be available from early 2014.

(B) Reducing variation (along the pathway).

Reduction of variation between providers and within providers

There is considerable variation in care provision both between providers and within providers. The continued implementation of the Best Practice Commissioning Pathways and unified clinical guidelines means that more people will receive optimal care.

Revenue funding for changes would be through activity changes within CCGs contracts with secondary care providers. Increasing the consistency with which people were treated should lead to reduced overall costs.

Consolidation of specialist services

The Model of Care set out the need to consolidate specific services onto fewer sites across London. Within N and E London, a number of service reconfigurations are being planned, including specialist urology, brain, thoracic, OG, head and neck and blood and marrow transplantation.

Revenue funding for such developments would come through specialist commissioning contracts with secondary and tertiary care providers.

Implementation of *Co-ordinate my Care* on a consistent basis across London

Palliative care services are not consistently available across London. The continued implementation of *Co-ordinate my Care* will allow more people to receive terminal care support in their place of choice.

Funding for the *Co-ordinate my Care* project has come from NHS England (London Region).

Implementation of national specialist commissioning service specifications

National service specifications have been developed for services which are commissioned by the specialist commissioning team. The implications of requiring providers to meet the requirements are being considered, so that the quality, financial and activity implications are understood, before being implemented.

Revenue funding for such changes would come from specialist commissioning contracts with secondary and tertiary care providers.

Implementation of a radiotherapy commissioning strategy

The development of a radiotherapy commissioning strategy during 2013/14 will provide a framework within which future service developments can be considered. This will include the development of a radiotherapy equipment replacement programme.

Revenue funding for the implications of a resulting strategy would come from specialist commissioning contracts with tertiary care providers.

Implementation of a chemotherapy commissioning strategy

The development of a chemotherapy commissioning strategy during 2013/14 will provide a framework within which future service developments can be considered.

Revenue funding for the implications of a resulting strategy would come from specialist commissioning contracts with tertiary care providers.

(C) Living with and beyond cancer.

The implementation of the living with and beyond cancer elements of the Best Practice Commissioning Pathways

Living with and beyond cancer pathways are being developed to be included, with Early Detection elements, in the revised Best Practice Commissioning Pathways. These will be included as service specifications within the 2014/15 contracts.

In addition, a series of quality indicators has been developed to monitor compliance with the pathways, including:-

- lymphoedema for the breast pathway
- sexual function for the prostate pathway
- pelvic radiation disease for the colorectal pathway

No additional funding is anticipated for implementing these quality indicators.

The extension of the Recovery Package:-

The objective is to build on the work in 2013/14, by both increasing the number and percentage of people who complete a Holistic Needs Assessment, increasing the number of people who have a Care Plan and a Treatment Summary, plus also extending the Recovery Package to include the development of a Health and well-being event.

In order to sustain recovery, planning is taking place associated with measures in the following areas:-

- physical activity
- work and finance

Revenue funding for the extension of the Recovery Package to include a health and well-being event would come through existing resources allocated to secondary care providers.

Focused patient experience measures

The current National Cancer Patient Experience survey does not adequately cover the issue of the primary/secondary care interface. The workstream is seeking to consider the introduction of focused patient experience measures covering this key area of interface.

No additional funding is anticipated for implementing these measures.

Restructuring of the Cancer Care Review

There is variability in implementation of the Cancer Care Review in primary care settings. This intention is to consider how the CCR could be enhanced, to ensure a more effective outcome.

Revenue funding for this would be delivered through agreeing additional QOF points associated with an enhanced CCR.

Consequences of treatment

The National Cancer Survivorship Initiative (NCSI) document from March 2013 also referred to the need to focus services where there are adverse consequences of treatment. For 2014/15, the following three areas are being targeted to develop quality improvement metrics associated with the consequences of treatment:-

- lymphoedema
- pelvic radiation disease
- sexual function

These have been developed and feature as quality indicators.

Supporting people with active and advanced disease

The workstream will develop these draft intentions during the autumn.

Stratified outpatient pathways

As part of the support for people living with and beyond cancer, a stratified approach is being implemented to support the self-management of patients (as an alternative to follow-up outpatient appointments). This will result in the discharge of significant numbers of patients from outpatient appointments and the development of greater supported self-management. This is taking place for patients following breast, prostate and colorectal cancer, with the impact on contractual volumes and new : follow-up ratios being calculated.

Engagement with key stakeholders - details.

The following sections describe the detail of the engagement that has taken place to develop the CIs.

The creation of 32 CCGs in London as sovereign bodies (which are not able to cede responsibility to other NHS bodies) means that the process of engaging and ensuring the buy-in for all cancer draft CIs is more complex than even the process used in 2012/13. CCGs across London are in very different strategic and financial positions and also view cancer services in very different ways; some see the transformation of cancer services as less of a priority than others, or than NHS England (London Region). Also, many CCGs are developing their overall CIs to slightly different timescales, meaning that the opportunity to influence individual CCGs is varied. All of this means that gaining the support from all 32 CCGs to all draft cancer CIs has been a significant challenge.

The development of NHS England as one organisation leading on specialist commissioning means that there is now far more central direction on this aspect of commissioning. This means that there is far less opportunity for innovation/development at a London-only level and the development of national Clinical Reference Groups could slow down the production of commissioning outputs, such as CIs.

London CCGs.

London CCGs have participated in activities since July to feed their priorities for cancer development into the process. During October and November, CCGs were asked to endorse draft cancer CIs.

Integrated Cancer Systems (ICSs).

The ICSs have an important role in ensuring the development of the cancer systems in London, through bringing together secondary and tertiary providers in their geographical area. This means that TCSL expects that ICSs will provide a co-ordination role and, through working with TCSL and CSUs, will support the development of a consistent provision of care across providers.

Cancer providers in London are the main recipients of the service improvements proposed by the Programme. This is more comprehensive than that which has been issued in previous years, meaning that there has been more discussion between the TCSL, ICSs and providers, to share the understanding of the CIs.

London CSUs.

London Commissioning Support Units (CSUs) have taken the draft cancer CIs contained within this document and discussed them with CCGs within their patch; this has been undertaken in a variety of ways, to ensure optimal engagement and buy-in and has been led by the two CCTs. CSUs will also be the mechanism through which contracts are agreed with acute providers for 2014/15.

Cancer Commissioning Team - West and South

The CCT wrote to each CCG Chair, Accountable Officer and Cancer Lead on 24th July to give a brief summary of the emerging draft CIs. This led to planned visits with most CCGs/groups of CCGs, with

only one declining a visit. The focus has been to discuss both the role and function of the CCT and also emerging information on draft CIs. Feedback from these visits has been very positive, with a greater understanding of the cancer agenda in London and of key personnel in the CCT and CCGs.

A meeting for CCG cancer leads in SE and SW London was held on 4th September; a meeting with NW leads was planned for October. The draft CIs have been discussed at a number of other locality and CCG meetings.

The CCT has continued their engagement over the autumn, with other information being disseminated as it became available. It was important to begin to understand the specifics of local issues and to give an indication of the likely cost implications for each CCG, as these were available (such as endoscopy).

In addition to the draft CIs contained in this document, the CCT also discussed the following issues with CCGs, to seek their support:-

- Prostate cancer risk-stratified community follow-up
- Issues arising from contract performance monitoring

Cancer Commissioning Team - North and East

The CCT organised a workshop on 16th July with all the CCGs in North East London and West Essex. This workshop was used to talk through the structure and work of the cancer commissioning team and how the CCT supported CCGs in their role to commission cancer services; also how the CCT works with the Integrated Cancer System, *London Cancer*, to improve cancer services. The background to the pan-London approach to commissioning intentions in cancer was explained to the meeting and a set of draft Commissioning Intentions was presented.

This meeting generated a lot of interest and questions, given the wide range of CIs being proposed. CCGs requested a second workshop in order to consider these in more detail and, in the intervening period, the CCT offered to meet each CCG individually. The second workshop took place on 17th September. This workshop discussed the draft pan-London CIs but also discussed local cancer commissioning priorities.

Seven of the 13 CCGs in NEL and West Essex attended the first workshop. Follow up meetings have been organised with 10 of the CCGs so far. During October and November, the CCT has completed any outstanding work in engaging with CCGs on cancer CIs.

Thoughts on 2014/15 Commissioning Intentions from individual CCGs are:-

- Barnet & Enfield – have a strong interest in diagnostic turnaround times (access to diagnostics in time, reports received in time and quality of reporting). Would like to see the College of Radiology guidance included within contracts.
- Haringey – seeking assurance about cancer outcomes by MDT and what meaningful KPIs could be devised that can be performance managed in-year.
- Camden – consideration of how to include items specific to out-of-hours service provision, and not exclusive to acute contracts

- Islington – endoscopy strategy and keen to see urgent gastroscopy available within 14 days, when needed. Palliative care on general wards is a concern.

Also a general concern has been expressed by most of the primary care cancer leads (PCCLs) about not having a holistic view of cancer commissioning. In essence, they are seeking assurance from NHS England about specialist cancer services, as well as assurance from the CCT about local cancer services, to be able to reassure their GP clinical colleagues about all cancer services in their patch.

Some interest has been expressed in a review of 100 day cancer waits breaches (against the 62 day national mandatory target) pan-London, to ensure patients that breach the target do not have lengthy delays to treatment.

The CCT will continue to work closely with colleagues in the CSU to ensure the development of Commissioning Intentions in cancer is consistent with other CSU support to CCGs in developing their Commissioning Intentions.

NHS England.

Specialist commissioning

The specialist commissioning team in NHS England (London Region) will take the draft cancer Commissioning Intentions contained within this document alongside the nationally-determined Commissioning Intentions and share them with London providers.

The national meeting to begin the conversation about the development of national Commissioning Intentions for specialist services took place on 10th September and, following that meeting, a set of national specialist commissioning CIs were issued in October. Further work is underway to refine these, for issue to provider during December.

Screening commissioning

Screening commissioning is handled by a different team within NHS England and the Programme team has been working with them to ensure that arrangements for 2014/15 are incorporated into the overall Programme. Screening commissioning is bringing together commissioning that used to take place on a sub-London basis. The team is implementing a national specification and is led by Public Health England.

Primary care commissioning

Primary care commissioning is undertaken by a different team within NHS England and, although primary care contracts do not operate to the same financial year timetable (as secondary care contracts), the intention is to seek to influence both primary care contracts in the future as well as Quality Outcomes Framework (QOF) arrangements for cancer-related items (e.g. Cancer Care Review). It is recognised that this will be a more complex process and one that will take longer to achieve.

Contractual levers in the standard NHS contract document.

The following sections of the NHS standard contract documentation are available to be used to document intentions for service improvement in 2014/15. Each workstream is expected to consider each of the following sections and categorise which changes they would wish to see against which heading.

There are a number of different parts within any NHS contract and these contain a wide range of levers that can be used with any service provider, including:-

- (a) Service specifications;
- (b) Quality Requirements;
- (c) Service Development and Improvement Plan (SDIP);
- (d) Quality incentive schemes (CQUINs);
- (e) Information Requirements;
- (f) Pricing;
- (g) Contract management.

Service specification

Within the contract documentation, there is a section relating to service specifications (section B, part 1), where the commissioner documents the service that they expect to commission. In many instances, the service specifications are an aspiration and do not yet represent the service that the provider can deliver, or that the commissioner expects to be delivered in the current year.

Service specifications may be developed to describe services in a number of ways, by care pathway, by cluster (mental health), by individual service, or by individual service user. The service specification is intended to be a brief description of the services being commissioned, including:-

- Population needs – national and local, including evidence base;
- Scope – objectives, linkages with other services;
- Applicable service standards – NICE or Royal College standards;
- Key service outcomes – headline outcomes.

Commentary on use in 2013/14 – the four Best Practice Commissioning Pathways were approved and included in contract documentation.

For 2014/15, it is anticipated that these will be expanded to include, where appropriate, the Early detection and Living with and beyond cancer elements of the pathways.

Quality Requirements

Within the contract documentation, there is a section relating to Quality Requirements (section B, part 8), where the commissioner documents quality indicators that the provider is expected to meet. This section will contain:-

- Nationally-mandated requirements
- Locally-set requirements

Each of the quality indicators will contain – the quality indicator, threshold, method of measurement and consequences of breach. In this way, there is clarity about what is expected of the provider and the consequences of not meeting the required standard.

There is scope within the locally-set requirements to be able to specify cancer-specific information requirements, to be included in the 2014/15 contract documentation and negotiated with all cancer providers.

Commentary on use in 2013/14 – the Programme made extensive and successful use of the Quality Requirements section, with most indicators included in nearly all contracts.

For 2014/15 – a small group (comprising commissioners and ICSs) has reviewed these for 2014/15, including:-

- More closely defining existing indicators, where there is some lack of clarity
- Defined provider response times for diagnostic services
- Reporting of Peer Review measures to commissioners
- Developing a London-wide response to 62 day cancer waits
- Screening indicators

Service Development and Improvement Plan.

The Service Development and Improvement Plan (SDIP) is a mandated plan (section B, part 11) that should be closely aligned with local commissioning plans and may include:-

- Productivity and efficiency plans;
- Any agreed service redesign plans;
- Service development plans;
- Any priority areas for quality improvement.

The SDIP will be reviewed through the contract review process.

There is scope to develop cancer-specific content for a SDIP to be included in the 2014/15 contract documentation and negotiated with all cancer providers.

Commentary on use in 2013/14 – this lever was not used at a Pan-London level, but was used at a local (provider level).

For 2014/15 – the use of this lever will be considered on a provider-by-provider basis.

Quality incentive schemes (CQUINs):

Quality incentive schemes can be included within the contract (section B, part 9) as a way of commissioners rewarding excellence, by linking a proportion of provider income to locally-agreed quality improvement goals.

A specific CQUIN relating to cancer services could be developed for 2014/15, as required, though there is no guarantee that CCGs, local contracting Account Teams and providers would choose to use any specific CQUIN. In addition, participation with the CQUIN framework is optional by providers, meaning that this is not the preferred way of guaranteeing service improvement.

Commentary on use in 2013/14 – a pan-London CQUIN associated with ‘compliance with the Best Practice Commissioning Pathways’ was developed, though not supported by London CCGs. Therefore, it was introduced at some providers only.

For 2014/15 – CQUINs are one lever where CCGs can be particularly focused, so it is not intended to develop a draft cancer CQUIN.

Information Requirements.

Within the contract documentation, there is a section relating to Information Requirements (section B, part 14), where the commissioner documents quality indicators that the provider is expected to meet. This section will contain:-

- Nationally-mandated requirements reported centrally
- Nationally-mandated requirements reported locally
- Locally-set requirements
- A Data Quality Improvement Plan (DQIP).

There is scope within the locally-set requirements to be able to specify cancer-specific information requirements, to be included in the 2014/15 contract documentation and negotiated with all cancer providers.

The DQIP allows the commissioner and provider to agree a local plan to improve the capture, quality and flow of data to support the commissioning and contract management process.

Commentary on use in 2013/14 – this was a well-used section and included the 31 commissioning metrics. CCTs are now using these to deliver improvement with providers.

For 2014/15 – this lever has been reviewed to include (as examples) the Early Detection and Population Awareness metrics and further metrics associated with living with and beyond cancer.

Pricing.

There are two types of prices specified in the contracts:-

- National tariff – this should be used for all services to which the national tariff applies, in line with PbR guidance. There are two variations to national tariff:-
 - National tariff plus Market Forces factor (MFF), also called full tariff
 - Variations to tariff prices
- Non-tariff prices – used for all services to which the national tariff does not apply

There is scope within pricing to be able to amend prices away from full tariff for 2014/15, or for current non-PbR prices to be reviewed.

Commentary on use in 2013/14 – this lever was not used.

For 2014/15 – there are options associated with the wide variation in non-PbR prices across London that will require careful consideration.

Contract management.

The contract documentation sets out the respective responsibilities of commissioners and providers in managing activity. Commissioners are responsible for managing the external demand for services;

providers must work with commissioners to understand and manage referrals. There are several and distinct parts of the process:-

- Indicative Activity Plan (IAP) - the commissioner and provider must agree an IAP, which is an indication of the activity expected during the contract year
- Activity Planning Assumptions (APA) - set out planning assumptions relating to how the provider will manage their internal activity once a referral has been accepted
- Prior approval schemes – any prior approval schemes should be notified by the commissioner prior to the start of each contract year

Through the contract review process, commissioners and providers will review the application of the contract, including issues such as service quality, finance and activity, information and general contract management issues.

Commissioners and providers should identify those areas requiring review, taking into account reporting requirements set out in the Quality and Information schedules.

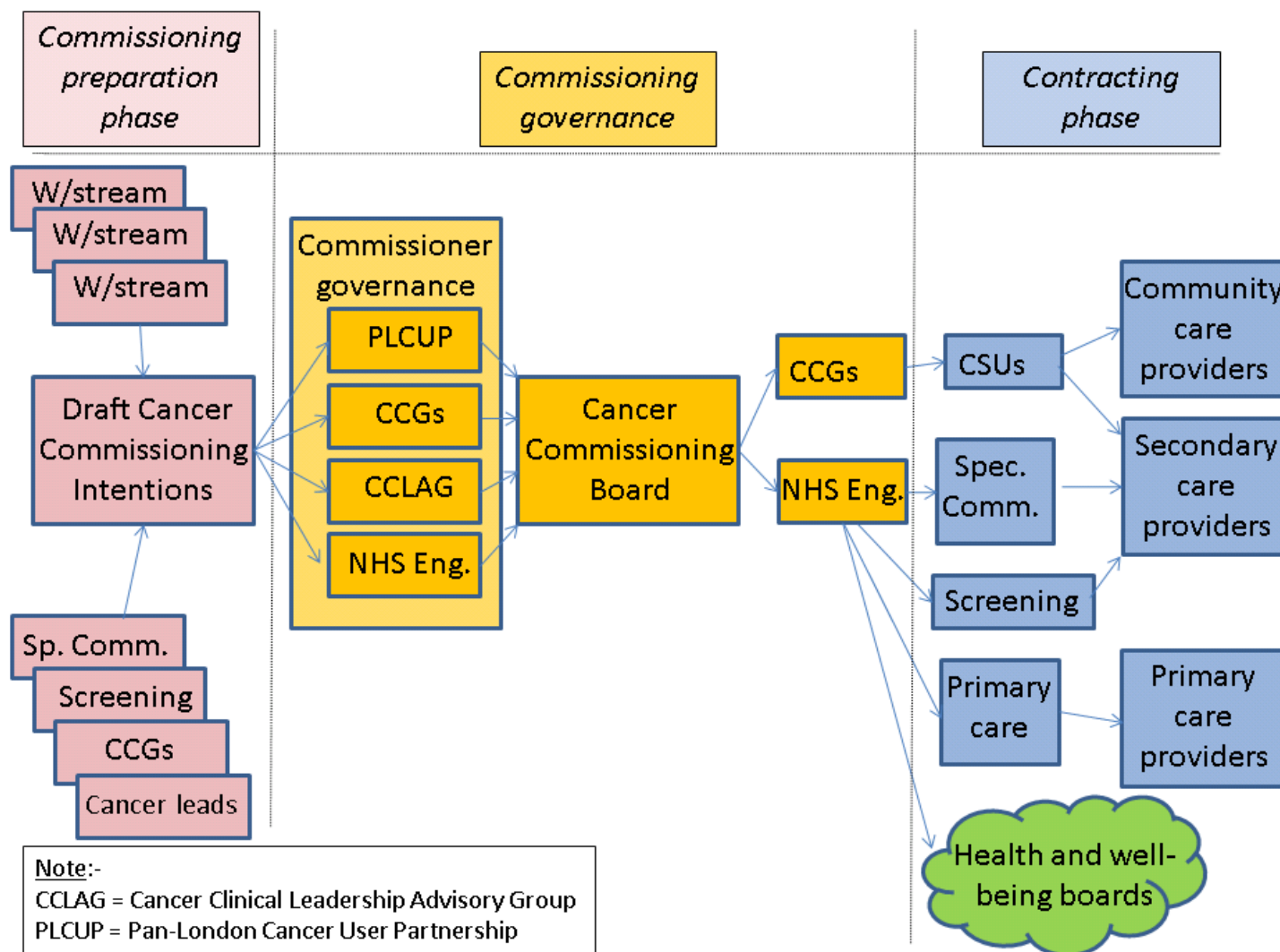
Through the contract management process there are a number of stages when performance does not meet the required standard.

This is an area where, Cancer Commissioning Teams (CCTs) work in conjunction with general contracting Account Teams (the team responsible for leading the contract negotiations and management with the provider) to highlight and raise issues of performance.

Commentary on use in 2013/14 – both CCTs are working with and as part of CSUs, to ensure that focused contract monitoring for cancer services takes place.

For 2014/15 – the role of the Transforming cancer Services Team (bringing together the work of the two existing CCTs and the TCSL team) will continue to ensure that there is a continuing focus on delivering the most effective contract management process.

Diagram showing the development and routing of cancer CIs 2014/15.



Transforming Cancer Services for London – Terms of Reference (Summary)

CANCER CLINICAL LEADERSHIP ADVISORY GROUP (CCLAG)

PURPOSE:

The Cancer Clinical Leadership Advisory Group will be responsible for providing clinical leadership and clinical advice to the London office of the NHS Commissioning Board and to the wider London cancer system. It is anticipated that the group will be aligned to the future clinical leadership model for the London region.

KEY AREAS / DELIVERABLES:

The Cancer Clinical Leadership Advisory Group will provide robust advice to the clinical leadership of the London region and the London Cancer Commissioning Board to commission world class cancer services. It will provide an annual review of the model of care, support the development and communication of priorities for the annual commission round, and offer advice in an ad hoc manner to ensure implementation of the cancer model of care.

MEMBERSHIP:

Chair: Medical Director – NHS England - London Region
Co-Chair: CCG and Primary Care Cancer Lead
5 x GPs / CCG Cancer Lead
6 x cancer clinicians to represent secondary and tertiary expertise from across London.
3 x senior specialist cancer nurses.
1 x Allied Health Professional
2 x User Involvement representatives

ATTENDEES:

(To attend CCLAG as required, to update on specific issues)

1 x Lead for specialised commissioning services (cancer)
1 x Head of Out of Hospital Service Transformation NHS England, London Region
2 x Commissioning Lead;

CANCER COMMISSIONING BOARD (CCB)

PURPOSE:

The Cancer Commissioning Board (CCB) will be responsible for providing overall leadership to London's Cancer System and ensure delivery of the Cancer Model of Care.

The CCB will be accountable to the NHS Commissioning Board London Regional Office.

KEY AREAS / DELIVERABLES:

- Sign off of commissioning intentions.
- Agreement and implementation of metrics for each pathway.
- Implementation of full pathway commissioning.
- Formal sign off of any departure from the model of care recommended by the CCLAG.
- Sign off of significant financial investment in line with standing financial instructions.

MEMBERSHIP:

Chair: NHS England – London Region
Co-Chair: Nominated CCG representative
1 x CCLAG Chair
2 x User Involvement representatives (rotational)
6 x CCG (CO / CL) representatives
5 x GP cancer lead (drawn from Cancer Clinical Leadership and Advisory Group)
2 x Commissioning Lead
1 x Head of Out of Hospital Service Transformation NHS England - London Region
1 x Divisional Director & Lead for specialised commissioning
2 x Public Health Representative x 2
1 x Programme Director

ATTENDEES:

To attend CCB as required, to update on specific issues:
1 x Programme Manager
1 x Development Lead

PAN-LONDON CANCER USER PARTNERSHIP GROUP (PLCUP)

PURPOSE:

Strong patient and carer or “user” involvement is to be at the heart of these changes, in order to ensure they improve the experience of service users and the quality of care they receive. In this context, the term “user” describes someone who has experience of London's cancer services either as a patient, or as the carer of someone who is a patient.

The Pan London Cancer User Partnership will be responsible for providing service user input into the plans for transforming London's cancer service at a strategic level. Some of these areas will require linking in with local user partnerships and other patient and public involvement groups. In such areas of cross over and collaboration it is important to note that the Pan London Cancer Partnership's role is to complement and support local groups rather than replace them. It is anticipated that the group will be aligned to the Cancer Commissioning Board and will contribute to the user involvement model for the London region. The group will be established initially for a fixed term of twelve months.

KEY AREAS:

The Pan London Cancer User Partnership will provide robust advice to the London Cancer Commissioning Board to commission world class cancer services. Two members of the group will each attend the quarterly Cancer Commissioning Board to present a user involvement perspective.

The group will provide an annual review of user involvement activity, support the development and communication of priorities for the annual commissioning round, and offer advice as required to ensure effective service user contribution to the transformation of London's cancer services.

MEMBERSHIP:

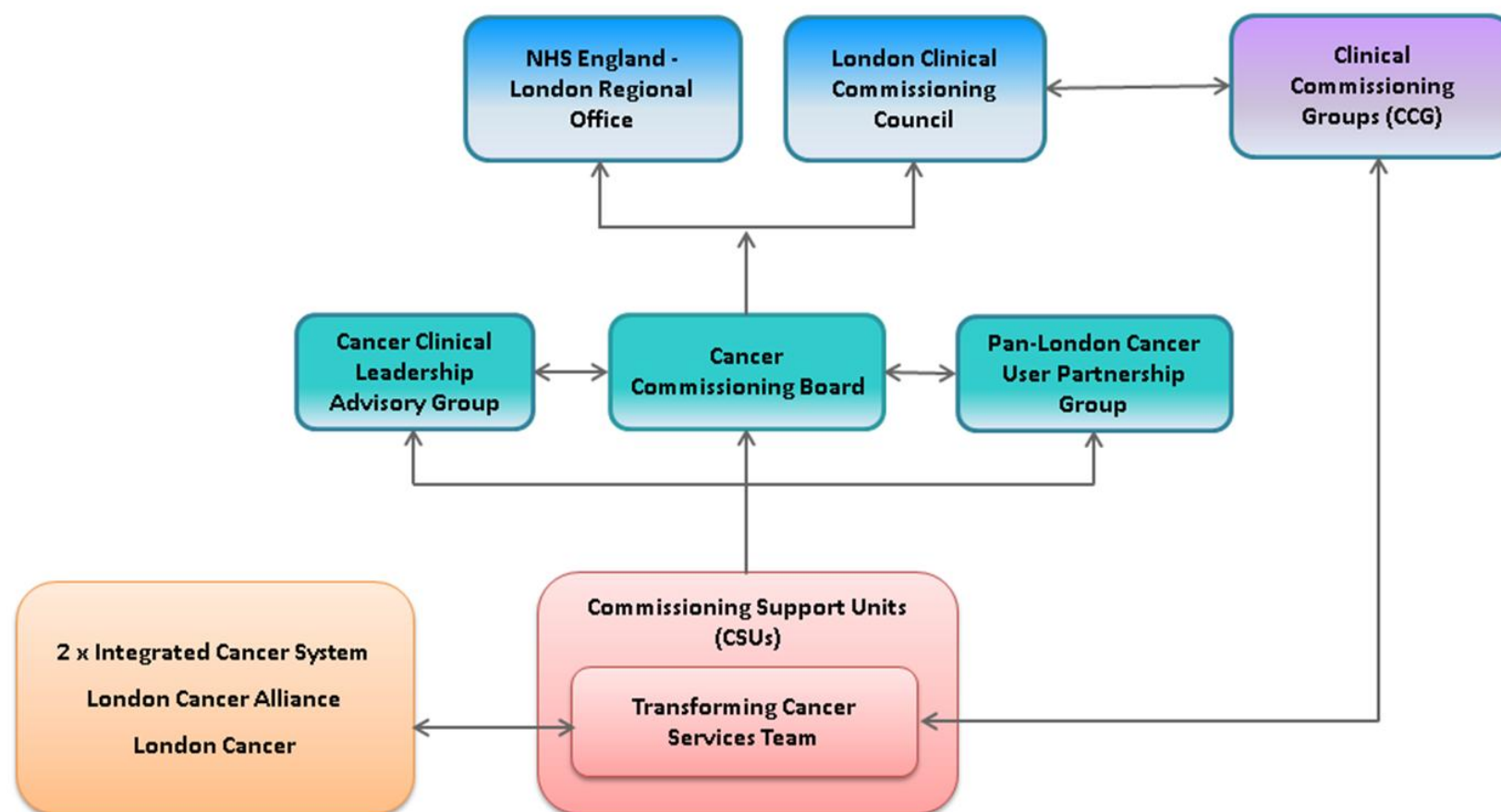
Chair
2 x service user representatives from each of the five geographies of London (i.e. North East, North Central, North West, South West and South East London)
At least one of the two service user representatives will have excellent links with their local user partnership.
User representation from the Cancer Clinical Leadership and Advisory Group
The user involvement leads (formerly facilitators) from each Cancer Commissioning Team

ATTENDEES:

To attend the Cancer User Partnership meeting as required

- The user involvement coordinators from each Integrated Cancer System
- User representatives from Cancer Programme Executive

Appendix 2: Transforming Cancer Services Team – Governance Structure



Appendix 4: Cancer Commissioning Board - Members

NAME	CCB ROLE	JOB TITLE	ORGANISATION / AREA
Helen Cameron	Chair – Cancer Commissioning Board (CCB)	Regional Director of Transformation	Transformation Directorate NHS England (London Region)
Paul Roche	Programme Lead	Programme Director, Transforming Cancer Services for London	Transformation Directorate NHS England (London Region)
Dr Andy Mitchell	Chair of the Cancer Clinical Leadership Advisory Group (CCLAG)	Medical Director	Medical Directorate NHS England (London Region)
Dr Clare Stephens	CCLAG / CCG representative	GP – Primary Care Cancer Lead	NC London
Chris Hudson	Member of the Pan-London Cancer User Partnership Group (PLCUP)	User Representative	London
Sonia Richardson	Member of the Pan-London Cancer User Partnership Group (PLCUP)	User Representative	London
Simon Williams	Specialised Commissioning Lead	Acute Programme of Care Lead	London Specialised Commissioning Group (LSCG) NHS England (London Region)
Karen Clinton	Primary Care Lead	Head of Primary Care Commissioning (NW London)	NHS England (London Region)
Andy McMeeking	Commissioning Lead	Cancer Commissioning Team Manager	NHS North & East London Commissioning Support Unit
Dr Cathy Burton	CCLAG / CCG representative	GP - Primary Care Cancer Lead	SE London
Dr Alex Tran	CCLAG / CCG representative	GP - Primary Care Cancer Lead	NE London
Dr Tony Brzezicki	CCLAG / CCG representative	GP – Primary Care Cancer Lead	SW London
Dr Pawan Randev	CCLAG / CCG representative	GP - Primary Care Cancer Lead	NW London

Dr Shahed Ahmad	Public Health representative (North London)	Director of Public Health	North London, Enfield Council
Dr Ellis Friedman	Public Health representative (South London)	Director of Public Health and Faculty Advisor	Sutton and South London
Dr Chris Streater	AHSN representative	Managing Director	Academic Health Science Network (AHSN) for South London
Prof. Adrian Bull	AHSN representative	Managing Director	Academic Health Science Network (AHSN), Imperial College Health Partners
Prof. David Fish	AHSN representative	Managing Director	Academic Health Science Network (AHSN), UCL Partners
Dr Josephine Ruwende	Public Health - Screening	Consultant in Public Health	NHS England (London Region)
Andrew Eyres	CCG representative	Chief Officer	NHS Lambeth Clinical Commissioning Group
Paul Haigh	CCG representative	Chief Officer	NHS City and Hackney Clinical Commissioning Group
Daniel Elkeles	CCG representative	Chief Officer	NHS Central London (Westminster) Clinical Commissioning Group
Dr Fran Woodard	Charity representative	Director for England	Macmillan Cancer Support
Sara Hiom	Charity representative	Director of Patient Engagement and Early Diagnosis	Cancer Research UK
Dr Neil Goodwin, CBE	ICS representative	Chair of the Members' Board	London Cancer Alliance
Pelham Allen	ICS representative	Chair of the London Cancer Board	London Cancer