

A Strategic Vision For Cancer

Wessex Cancer Strategic Clinical Network

Foreword

At the Wessex Cancer Strategic Clinical Network, we are committed to improving the outcomes for cancer patients.

We are aware of the significant healthcare challenge cancer presents, but already improvements in outcomes mean that 50 per cent of people will now live for 10 years or more after a cancer diagnosis.

This very welcome news does not change the reality that further clinical and patient experience outcome improvements must be made for the benefit of us all. But we can all play our part in this, whether we are users, providers or commissioners of healthcare – our aspiration must be for everyone to live longer healthier lives, and at the same time to make responsible decisions about the use of the resources available to us to achieve this end.

This strategic vision for cancer has been developed by the Wessex Strategic Clinical Network for Cancer, and is our blueprint for the future of cancer services. It has been written primarily with those who commission and provide cancer services in mind, but we hope will be of much wider interest.

It builds on the excellent work of previous cancer networks and has been produced after extensive consultation across the area with a wide range of stakeholders from all the healthcare professions; primary and secondary care providers, public health, clinical commissioning groups (CCGs), specialised commissioners and perhaps most importantly, the public and those people who are currently living with cancer.

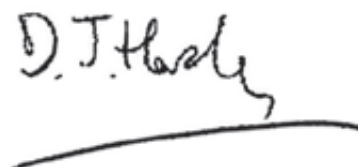
We believe that the recommendations we have made are well-evidenced, broad in range and consistent with the current and future aspirations of the wider NHS.

Above all, we believe that the implementation of these recommendations will make a real difference; we commend them to you, and we look forward to working with you to implement them.



Matthew Hayes

Clinical Director
Cancer Strategic Clinical Network
NHS England (Wessex)



Dominic Hardy

Director of
Commissioning Operations
NHS England (Wessex)

Contents

Foreword	2
Contents	3
1 Executive summary	6
2 Acknowledgments	10
3 Aim of this strategic vision	11
3.1 What is the Strategic Clinical Network (SCN) for cancer?	11
3.2 What does this mean for cancer?	11
4 Development of this strategic vision	13
5 Context and alignment with strategy and priorities	14
5.1 National and local policy and strategy alignment	14
5.2 Context – the national picture	14
5.3 Context – Wessex geography	17
5.3.1 Our structure and key relationships	17
5.3.2 The population of Wessex - and what this means for planning	18
5.3.3 Cancer incidence and outcome information for Wessex.	20
Ambition 1	25
6 Underpinning quality principles	26
7 Prevention	27
7.1 Key recommendations	27
7.2 Context: national and local strategies.	28
7.2.1 Primary prevention	29
7.2.2 Screening - in prevention and early detection	32
7.2.3 Secondary prevention	34
Ambition 2 – prevention by 2020:	35
8 Early awareness, early detection	36
8.1 Key recommendations	36
8.2 Context: national and local policy	37
8.3 Context: national and local demographics	37

8.4	The case for change - what this means for Wessex	38
8.4.1	What are we doing well?	38
8.4.2	What do we need to focus on?	38
	Ambition 3.	42
9	Treatments for the best outcomes	43
9.1	Key recommendations	43
9.2	Context - national and local policy	45
9.2.1	Access and equity	45
9.2.2	Healthcare workforce	45
9.2.3	Service configuration	46
9.2.4	Personalised treatment and management	48
9.2.5	Enhanced recovery.	50
9.2.6	Patient experience	50
9.2.7	Accelerated adoption of technologies	50
9.3	The case for change - what this means for Wessex	51
9.3.1	Access and equity	51
9.3.2	Healthcare workforce	53
9.3.3	Service configuration	53
9.3.4	Personalised treatment and management	53
9.3.5	Enhanced recovery.	54
9.3.6	Patient experience	54
9.3.7	Accelerated adoption of technologies	54
	Ambition 4.	55
10	Living with and beyond cancer.	56
10.1	Key recommendations	56
10.2	Context - national and local policy	58
10.3	Context - national and local demographics	58
10.4	The case for change - what this means for Wessex	59

10.4.1	Recovery package implementation.	59
10.4.2	Risk stratified pathways	59
10.4.3	Access to services	59
10.4.4	Education, training and development of the workforce	59
10.4.5	Where have we made a difference to date and areas of focus	60
	Ambition 5.	60
11	Drivers and enablers	61
12	Constraints, limitations and risks	62
13	Looking to the future and the role of research	63
	Ambition 6.	66
14	Implementation	67
14.1	Leadership and membership	67
14.2	Measures for improvement	67
14.3	15/16 commissioning plans	67
15	References	68

Approval

this document must be approved by the following of the NHS England (Wessex) team:

Name	Signature	Title/ Responsibility	Date	Version
Matthew Hayes		Clinical Director, Cancer Strategic Clinical Network		
Stuart Ward		Medical Director		
Dominic Hardy		Director of Commissioning Operations		

1. Executive summary

The Wessex Clinical Commissioning Groups (CCGs) proposed that the SCN be tasked with describing a strategic vision for cancer services over the next five years. This proposal was ratified by the Wessex Team in the summer of 2014. This decision was driven by acknowledgement of the significant national drivers for change, namely:

- Half of people with cancer survive at least 10 years¹
- There has been a 50% increase in suspected cancer referrals since 2009/10¹
- The number of people living with cancer in 2010 was approximately 2 million; this is expected to rise to 4 million by 2030²
- The 62 day waiting time target achievement has dropped below 85% standard for the first time and is at its lowest level since 2009/10¹
- £20bn is to be saved by NHS by 2014/15 with a projected additional £30bn funding gap between 2013/14 and 2020/21¹
- In 2012/13 UK cancer spend £5.7bn compared to £5.9bn in 2009/2010¹

The vision is based entirely on views of the local population and its needs.

The Wessex Cancer Strategic Clinical Network has set down a series of ambitions for local cancer care with a view to achieving the aims identified as priorities for us by patients, carers and healthcare providers throughout our consultation. These ambitions are designed to stretch services to improve on current achievements. Some are measureable within existing programmes (screening as a part of the public health programme for example.) For others, the measures and baselines will be set out over the next six weeks.

Cancer is by far the biggest cause of death in adults under the age of 75.

Ambition 1 Cancer survival:

Over the next five years cancer survival in Wessex will continue to exceed the England average, and will improve by 5% across all cancers.

The World Health Organisation (WHO) recognises that: "Prevention offers the most cost-effective long-term strategy for the control of cancer."³ Smoking is the cause of 19% of all cancer cases.⁴ Other lifestyle factors (alcohol, diet, exercise and excess weight) cause 32% of all cancer cases.⁵ Research indicates that people with serious mental illness are 2.6 times more likely to develop cancer than the general population.⁶

Wessex should meet the minimum standard in every general practice for all screening programmes, for as long as their efficacy is endorsed by NICE.



Ambition 2 Cancer prevention by 2020:

- a. Smoking prevalence age 15 years will be below the national average
- b. Smoking prevalence in adults will be below the national average
- c. Parity of smoking cessation between the wider population and people with a serious mental illness for the Wessex population
- d. Aggregate % of all adults achieving at least 150 minutes exercise per week above the national average (currently 55%)
- e. Aggregate % of adults classified as overweight below national average (currently 64%)
- f. All healthcare provider settings to be aware of and endorse the European Code Against Cancer⁷ recommendations for cancer prevention
- g. All practices will achieve at least the national minimum uptake for all cancer screening programmes
- h. Every practice in Wessex will achieve at least the 90% HPV vaccine target

Earlier diagnosis of cancer should be a top priority for both commissioners and providers alike. After prevention, early detection is the most effective tool against premature mortality from cancer and enables the most economically viable of treatment options.

The NHS England Five Year Forward View (2014) (5YFV), describes that “Cancer survival is below the European average, especially for people aged over 75, and especially when measured at one year after diagnosis compared with five years. This suggests that late diagnosis and variation in subsequent access to some treatments are key reasons for the gap.”⁸

Ambition 3 Cancer detection:

- a. The proportion of patients presenting as an emergency with a new cancer diagnosis will be below the England average across all nine CCGs in Wessex, aiming for an aggregate figure of 15% by 2020
- b. The proportion of patients diagnosed with early stage (stage 1 and 2) disease will improve by 20% across Wessex from around 50% currently

The principles behind delivering high quality equitable cancer care are described in detail in the NHS Outcomes Framework,⁹ in Improving Outcomes: A Strategy for Cancer,¹⁰ and in NICE guidelines covering specific diseases and technologies. Cancer treatment options are not currently always provided equitably, even within the same locality, and additionally not all patients can access a range of options, particularly in relation to newer treatment modalities.

Ambition 4 Patient experience

- a. Within 5 years all patients will receive cancer care in Wessex on the basis of a personalised, evidence based treatment pathway designed to optimise both outcome and experience**
- b. No patient requiring cancer treatment using modern radiotherapy technologies, other than proton beam therapy, will need to travel outside Wessex for treatment unless as a result of patient choice**

The 5YFV refers to those living with and beyond cancer and recommends the importance of: "...the provision of the Cancer Recovery Package, to ensure care is coordinated between primary and acute care, so that patients are assessed and care planned appropriately."⁸

Ambition 5 Rehabilitation and recovery:


Within 5 years all Wessex patients with a new cancer diagnosis will be offered a holistic needs assessment, a primary care cancer review and a detailed treatment summary, as a consequence of the implementation of the Recovery Package.

The UK has the highest recruitment to clinical trials in the world, with one in every five people newly diagnosed with cancer being placed in a study.

Ambition 6 Cancer clinical trials:

All cancer patients who are eligible will be offered recruitment into a clinical trial, aiming for an aggregate at or above the national level.

This strategic vision sets out the current status of cancer services in Wessex and outlines local priorities for the next five years. We will work closely with



our partners to develop a delivery plan which will describe specific ambitions in more detail and how we intend to reach these. We will establish a Wessex Cancer Alliance (WCA) which will have oversight of the agreed delivery plan and ensure ambitions are realised accordingly to agreed timescales.



2. Acknowledgments

We are very grateful to all those, too numerous to mention by name, who were able to either attend our stakeholder events or contributed their views in person, by phone, in writing, or on-line. We have used quotes throughout the document taken from the on-line survey and stakeholder events.

All reports of our stakeholder engagement are available on the cancer SCN website: www.wessexscn.nhs.uk/network-structures/cancer/

We would like to extend our gratitude to the planning group of expert primary and secondary care clinicians, public health, research and commissioning professionals who willingly gave up their time and have shaped and contributed to this strategic vision.

Particular thanks go to: Dr Bob Coates, Consultant in Public Health; June Davis, SCN Allied Health Professional Lead; Mr Matthew Hayes, Clinical Director, Cancer SCN; Jemma Jones, Communications and Engagement Advisor; Wendy Keating, Quality Improvement Lead; Dr Richard Osborne, Consultant in Medical Oncology; Sally Rickard, Manager, Cancer SCN; Dr Richard Roope, Macmillan Primary Care GP Lead; Clare Simpson, Consultant in Public Health, NHS England; Jo Wall, Quality Improvement Lead; Jocelyn Walters, CRN Manager; Teresa Warr, Specialised Commissioning, NHS England.



3. Aim of this strategic vision

This document is aimed at healthcare commissioners, patients, the public, providers and the voluntary sector. In this vision the Wessex Cancer Strategic Clinical Network aims to set out recommendations to improve the health and wellbeing of people affected by cancer.

3.1 What is the Strategic Clinical Network (SCN) for Cancer?

Strategic Clinical Networks support areas of major healthcare challenge where a whole system, integrated approach is needed to achieve a real change in quality and outcomes of care for patients. SCNs work in partnership with commissioners, supporting their decision making and strategic planning. Our overall aim is to address local variation and inequalities in health outcomes and experience across the domains which are identified in the NHS Outcomes Framework,⁹ as areas where major health challenges and inequalities exist.

SCNs are tasked to bring about:

- Large scale change across very complex pathways of care, involving many professional groups and organisations
- Best approaches to planning and delivering services
- Coordinated, combined improvement approaches to overcome healthcare challenges, which have not responded previously to other improvement efforts

In this way, the SCNs will:

- Reduce unwarranted variation in health and wellbeing services
- Encourage innovation in how services are provided now and in the future
- Provide clinical advice and leadership to support decision making and strategic planning

3.2 What does this mean for cancer?

Whilst cancer incidence is on the increase, our survival rates are getting better with over half of all cancer patients now surviving for 10 years or more.¹ This is of course a positive development, yet UK survival rates remain lower than some of the top performing countries in and beyond Europe and we must do more to ensure that people with cancer get the best care possible. A well-functioning local NHS with high quality cancer services is crucial if we are to meet the future needs of our population and improve local cancer outcomes.

These are clearly challenging times:

- There is rising demand for services and a lack of resources to respond to this capacity challenge

- There is fragmentation of care and commissioning across cancer patient pathways

We recognise that patients, carers, healthcare providers and commissioners need to understand what good cancer services should look like. The role of the SCN is to shape this, and to translate this into plans and recommendations for cancer care in Wessex.

Our aim is to ensure that we:

1. Reduce the incidence of cancer
2. Ensure every person who develops cancer can access high quality services via the most appropriate pathway
3. Ensure every person who develops cancer is offered high quality information, support, advice and care
4. Use information to prioritise and target where we can reduce inequalities

Specialised services for cancer are specified and commissioned at a national level, advised by Clinical Reference Groups. This strategic vision has been informed by our local Clinical Reference Group representatives, and while this is based on our local population needs and wishes, we hope that it will also be used to influence change at a national level.



The vision should be driven by clinical evidence and need, not only by targets. I accept using targets has improved diagnostics and to some extent treatment plans but diverted managers focus away from the patient as an individual.¹¹

Comment from a healthcare professional.



We take this point seriously. This document aims to set out a clear, shared vision for high quality, consistent and equitable cancer services for the whole population of Wessex. However, we recognise this must be coupled with prioritising the prevention of cancer, which is why we have co-developed this strategic vision with local public health experts.



4. Development of this strategic vision

“The NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them. But it also needs to evolve to meet new challenges: we live longer, with complex health issues, sometimes of our own making. One in five adults still smoke. A third of us drink too much alcohol. Just under two thirds of us are overweight or obese. These changes mean that we need to take a longer view”

The NHS Five Year Forward View, 2014.⁸

Before the above document was published in October 2014, the Wessex Strategic Clinical Network had begun the development of a five year strategic vision for cancer services, mandated by the 9 Clinical Commissioning Groups (CCGs) who commission healthcare on behalf of the population of Wessex.

We have held a number of stakeholder events, and engaged with both professional and patient/carer groups to gather insight into our population's needs and wishes. We undertook an online survey, to enable people within Wessex to identify their priorities for cancer, and received 311 responses. Two hundred and twenty one survey participants described themselves as professionals, and ninety survey participants described themselves as a patient affected by cancer. The full report is available at:

www.wessexscn.nhs.uk/network-structures/cancer/resources/

In our survey, the top priorities for patients were:

1. Getting the right treatment
2. More cancers are diagnosed earlier
3. Getting the right support

Professionals were asked to rank the priorities that our previous stakeholder events had identified. Overwhelmingly, professionals ranked prevention and early diagnosis as the top priority. The top five ranked priorities are:

1. Prevention and early diagnosis
2. Treatment decisions based on best available evidence/outcomes data
3. Evidence based screening programmes
4. Access to a range of treatment options
5. Access to specialised palliative and/or end of life care

The following vision is based entirely on views of the local population and its needs. This strategic vision does not include recommendations around end of life (EoL) care as this is in development as part of the Wessex EoL steering group work. When this work is published, it will be included in an updated version of this document.

The themes that emerge overlap significantly with the NHS Five Year Forward View – but this is not as a consequence of a deliberate decision to do so. This is simply reflective of the fact that these priorities are more widely shared.

5. The context and alignment with strategy and priorities

5.1 National and local policy and strategy alignment

A new national cancer strategy document is likely to be published in the near future developed by the new National Cancer Taskforce. The taskforce has been set up to focus on better prevention, speedier diagnosis and better treatment and aftercare for all those with cancer.

At the time of publication, nationally cancer waiting time standards are not being met consistently. Trusts across the country, including in the Wessex area, are no longer consistently achieving the referral to treatment time standards.

Further centralisation of certain highly specialised services has been discussed, including a requirement to deliver higher volume treatments in view of the outcome evidence in some disease areas. The details of what this might imply are yet to be published as part of the wider review of specialised services, but it seems unlikely that it would result in very significant change in the delivery of most cancer patient pathways in Wessex.

Local CCG commissioning plans and strategies have been reviewed and contain limited descriptions of any ambitions or aspirations specifically related to cancer diagnosis, management or ongoing care. Cancer is identified by all our partners' Joint Strategic Needs Assessments and Joint Health and Wellbeing Plans as one of the leading reasons for potential years of life lost in Wessex.

The Cancer Strategic Clinical Network has been tasked by the NHS England South (Wessex) Team to describe our ambitions for improved cancer care across the whole of Wessex.

This strategic vision is supported by aligned plans and guidelines which are currently under development across the other strategic clinical networks and senate. These include Strategic Clinical Network Visions for:

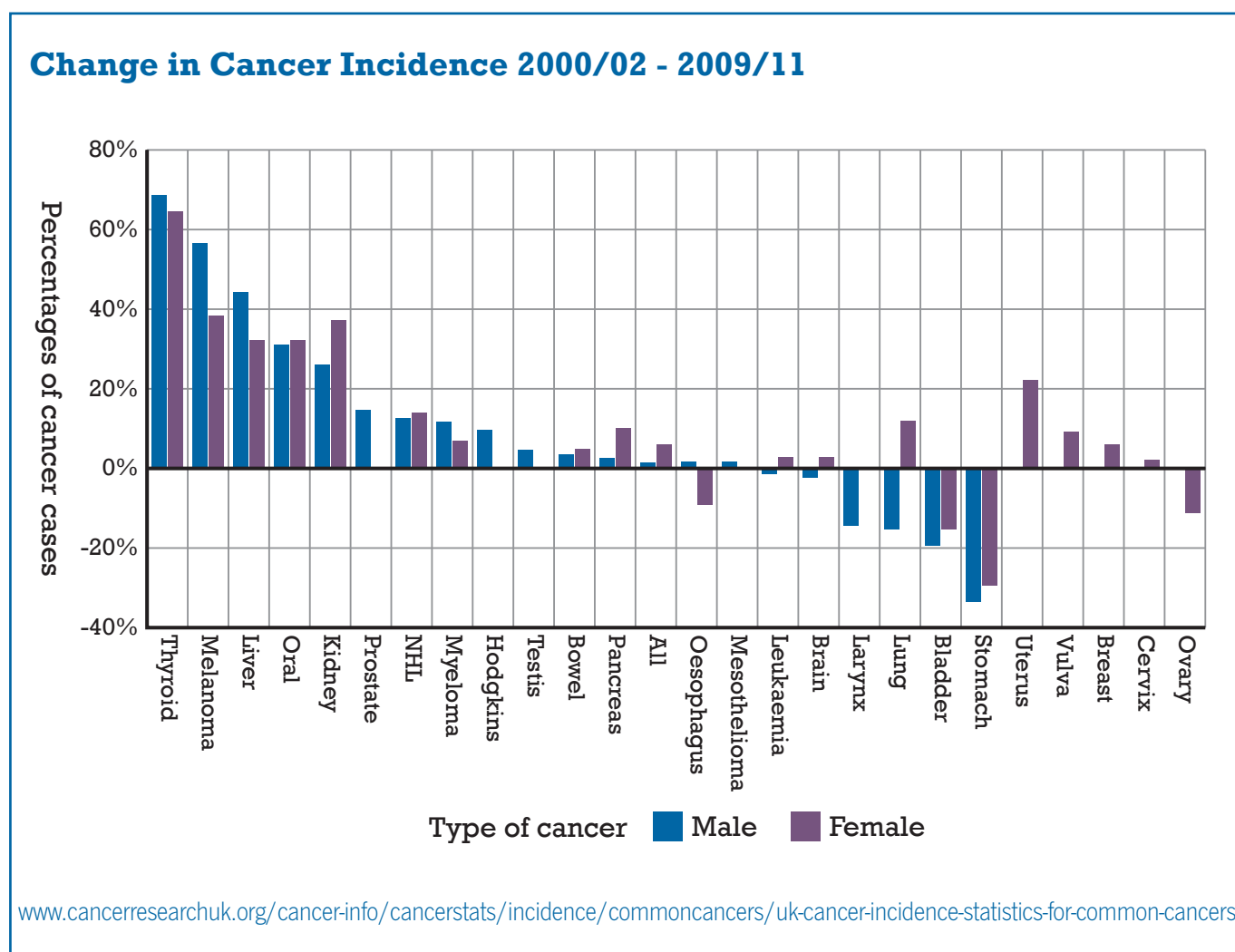
- Cardiovascular Disease
- Children and Young People
- Maternity
- Mental Health, Dementia and Neurological Conditions

Context – the national picture

5.2 The challenge of the delivery of high quality healthcare for all cancer patients remains a significant one. We are expecting the incidence of cancer to increase significantly, against a background of financial austerity: a projected £30bn funding gap between 2013/14 and 2020/21. We have already experienced the impact of reduction in real terms spending according to Cancer Research UK (CRUK). In 2012/13 the UK cancer spend was £5.7bn compared to £5.9bn in 2009-2010.¹ We recognise the challenges presented in recommending service improvements which may have cost implications in this context.

We know that in the UK, the incidence of cancer is expected to rise, both with the increasing age of the population¹² and the projected changes to lifestyle (rising obesity, declining diet health and levels of exercise).

It is also recognised that there will be changes in incidence of specific cancers:

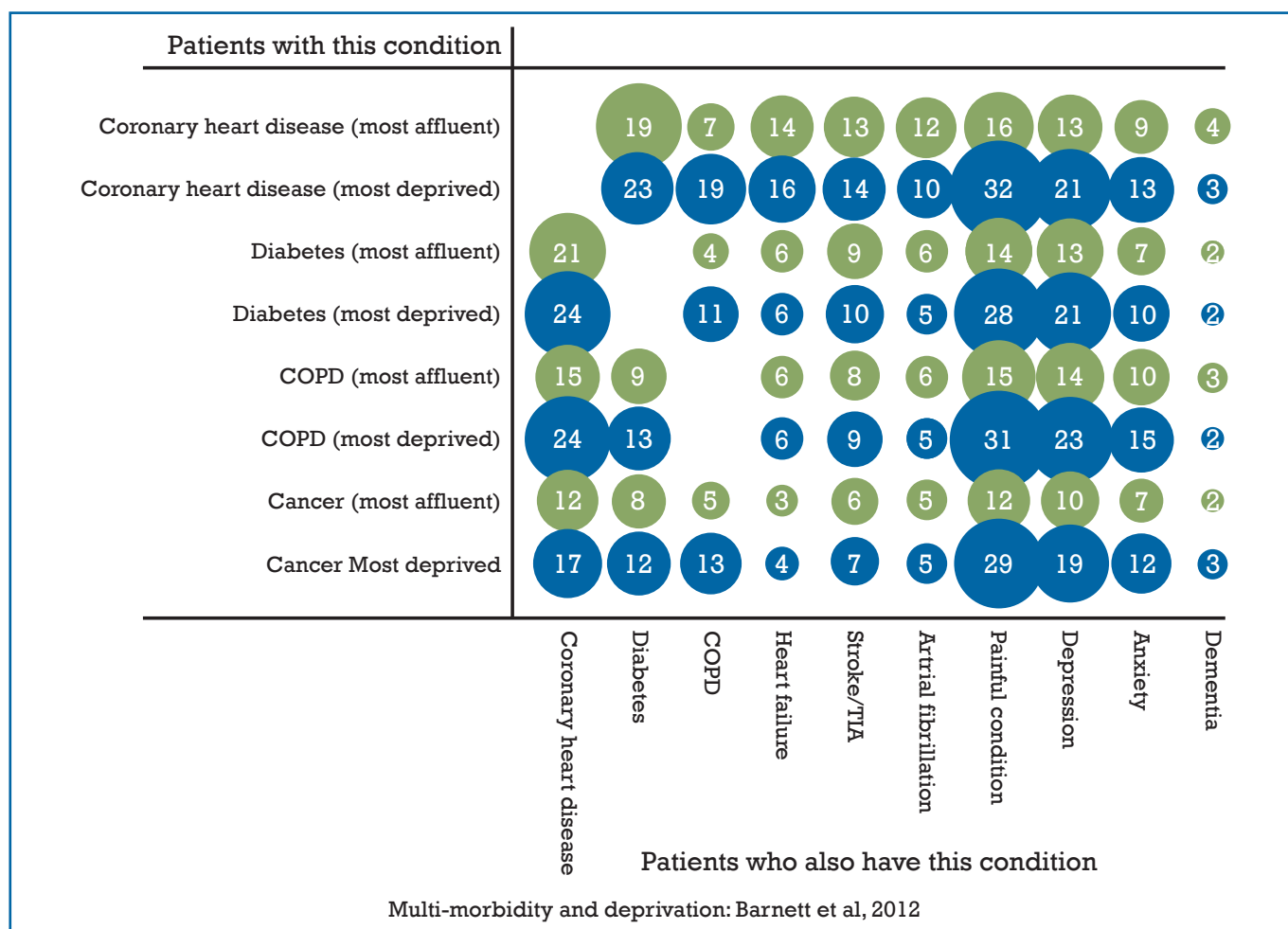


These trends are likely to continue unless aetiological factors change. Commissioners and providers will need to be aware of these projections and prepared to be proactive in adjusting services accordingly. The SCN can support commissioners in service planning and design, for example, to reflect the increase in melanoma and kidney cancer, and the reduction in stomach and ovarian cancer incidence.

The positive improvement in outcomes as a result of the successes of screening (which links to both prevention and earlier detection), earlier

diagnosis and improving treatments has led to more people surviving cancer. Nationally half of people with cancer now survive at least 10 years.¹ However, this group of people are now at potential risk of developing subsequent cancers. In the future we would expect that increasing numbers of cancer survivors will therefore develop second and even third primary malignancies or recurrence. Nationally, the number of people living with cancer in 2010 was approximately 2 million; this is expected to rise to 4 million by 2030.²

We recognise that for commissioners, clinicians and patients, cancer needs to be considered and managed in context of people's lives - which may include associated co-morbidities, and will be impacted by associated deprivation indicators - which we know affect incidence and survival rates. A recent Scottish epidemiological study demonstrated that a significant proportion of people will be suffering from more than one long term condition and related multi-morbidity¹³ against a context of deprivation indicators, as illustrated below:

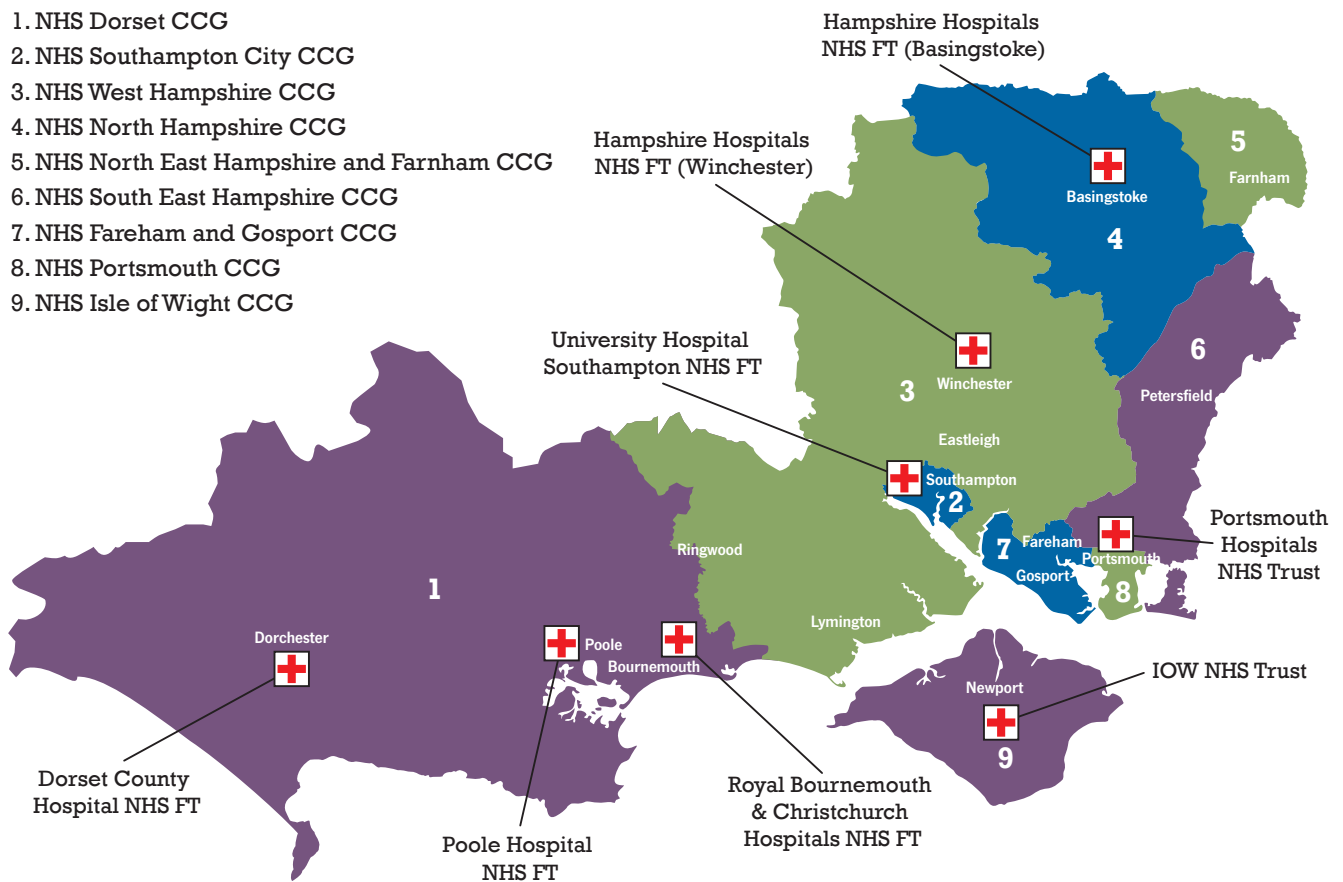


To address this will require a whole pathway approach – tackling issues from pre-conception to the end of life.

5.3 Context – Wessex geography

Geographical Boundaries and Partner Organisations of the Wessex SCN (December 2014)

1. NHS Dorset CCG
2. NHS Southampton City CCG
3. NHS West Hampshire CCG
4. NHS North Hampshire CCG
5. NHS North East Hampshire and Farnham CCG
6. NHS South East Hampshire CCG
7. NHS Fareham and Gosport CCG
8. NHS Portsmouth CCG
9. NHS Isle of Wight CCG



5.3.1 Our structure and key relationships

The SCN is hosted by the Wessex Team of NHS England. The map above shows our related Clinical Commissioning Groups (comprised of 318 member GP practices) and Acute Providers. We also have very close links with border providers, for example Salisbury District Hospital, Frimley Park Hospital, St Richard's Hospital based on patient flows, and local and specialised commissioning arrangements.

To support the planning and care of our 2.8 million population, we are also partners with Specialised Commissioning, 7 Local Authorities, the Clinical Research Network, the Academic Health Science Network, Health Education (Wessex) and NHS England Public Health Commissioning team, and are linked with 17 District Councils, 6 Health and Wellbeing Boards and a wide range of third sector organisations.

We have re-developed the clinical Site Specific Groups who provide multi-disciplinary advice based on clinical expertise. We also have good links and relationships with Wessex representatives of National Clinical Reference Groups, to ensure that information flows are effective from local priority to national planning.

5.3.2 The population of Wessex - and what this means for planning

Our role is to support the identification of current or future health inequalities, and to lead the whole system to ensure that cancer is prevented where possible, and managed proactively and equitably when it is detected. There is a range of demographic profiles within our population (based on local population data taken from the 2014 CCG commissioning strategies and Joint Strategic Needs Assessments), some of which are described below.

5.3.2.1 Age related demography:


In the Wessex area we have an older population (20.2% aged over 65) compared to the national England average of 17.3%.¹⁴ However, within that, we have areas where the age of the population is significantly higher than average (for example, Dorset and the IOW). As the populations in Hampshire and Dorset age, cancer incidence can be predicted to increase in the future. However, within Wessex there are areas where we have growing numbers of births and younger people (for example, in Southampton City: 16.9% are aged 18-24 compared with England average of 9.2%).¹⁴ We should anticipate an increase in the incidence of both childhood and young people's cancer in these areas.

5.3.2.2 Deprivation related demography:

Wessex is considered to be relatively affluent. However, our area includes areas of deprivation (based on Indices of Multiple Deprivation (IMD), which has a significant impact on both cancer incidence and related outcomes.

Potential reasons for the higher incidence and poorer outcomes associated with deprivation include:

- Late stage at presentation
- Lower uptake of screening
- Lower personal locus of control and seeking treatment options
- Less well managed existing co-morbidities
- Financial impact of cancer treatment and travel
- Impact of wider determinants of health (i.e. housing, social situation)



Conversely, we also know that people living in the least deprived areas have a higher incidence of particular cancers. For example, higher breast cancer rates are found in affluent areas of Hampshire.¹⁵

5.3.2.3 Ethnicity related demography:

Wessex has a predominately white British population; some areas have significant populations of diversity in both race and culture. Overall, people from Asian and mixed communities are 20-60% less likely to develop cancer than the white population, whereas for Black men the risk of developing cancer is comparable to white men. However, there is variation by cancer site. For example, Asian people are between one and a half and three times more likely to get liver cancer than the white population in England and Black men are twice as likely to develop prostate cancer than white men in England.¹⁶

There are known issues of inequality, one example being the low screening uptake of the Nepalese population in North East Hampshire. Dorset and the South West, for example, have comparably higher number of gypsy and traveller populations, who are known to have poorer outcomes, linked to culture and access and uptake of services. In recent years the number of people who are unable to speak English, or who don't use English as their first language, has grown significantly across our area. We know that this can cause issues around access to services, understanding of treatment options and can have implications to health outcomes. CCGs and local authorities know their populations best - the SCN can add value in sharing wider system approaches, support and expertise in models and interventions that have been found to have most impact.

5.3.2.4 Our geography:

As a popular tourist area, roads across the coast can be congested and there are limited routes to the majority of our main acute providers. National reports imply that people in Wessex have good access to cancer centres; however these include travel times which are based on off-peak travel, with access to private transport¹⁷. However, patients tell us that significant numbers of our population don't have private transport, and where they do, those who live in rural areas are not able to access cancer centres within a 45 minute drive - as recommended by the National Radiotherapy Advisory Group (NRAG).¹⁸

Most of our acute providers are poorly served by rail links close enough to be used. For those living on the Isle of Wight, travel to the mainland is expensive and time consuming, and impossible on occasions of very bad weather.

We recognise the importance of carefully considering our geography and the issues this presents when developing recommendations around service configurations, for the population we serve.

5.3.3 Cancer incidence and outcome information for Wessex

Cancer incidence and mortality trends follow the national trend - although across Wessex as a whole, outcomes compare favourably with England averages.

5.3.3.1 Incidence (number of new cancer cases each year):

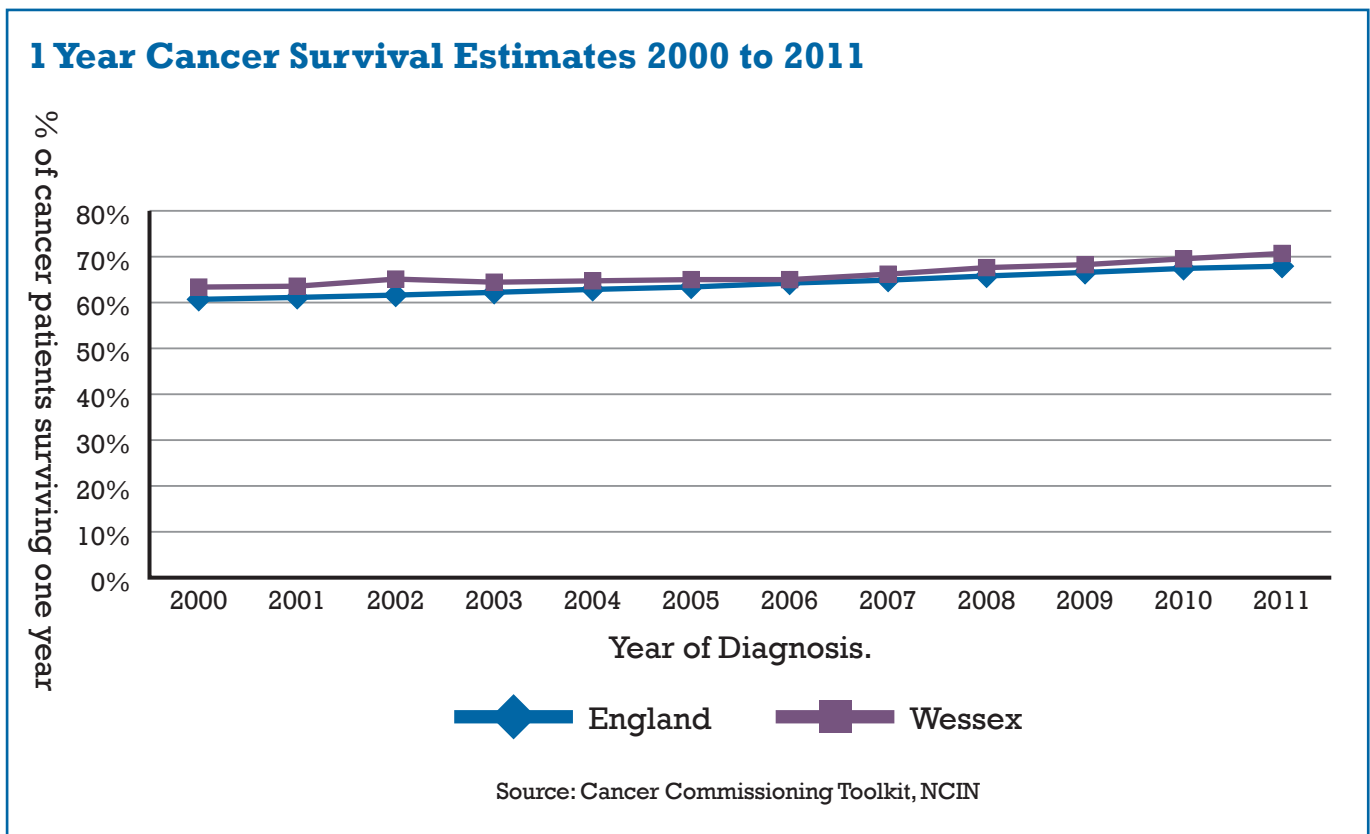
2012	Brain/ CNS	Breast	Endo- crine	Gynae	Haema- tology	Head and neck	Low GI	Lung	Other	Sar- coma	Skin	Up GI	Uro- logy	Total
NHS Dorset CCG	85	821	50	285	473	159	708	585	119	52	268	510	1336	5451
NHS Fareham and Gosport CCG	23	212	9	96	88	28	165	167	27	9	58	111	183	1176
NHS Isle Of Wight CCG	22	165	7	71	71	30	145	136	28	9	61	100	329	1174
NHS North East Hampshire and Farnham CCG	10	140	7	52	92	28	146	100	20	8	49	87	202	941
NHS North Hampshire CCG	24	178	9	56	101	25	158	91	24	11	57	88	208	1030
NHS Portsmouth CCG	13	131	13	73	75	33	139	140	28	3	44	96	158	946
NHS South Eastern Hampshire CCG	15	193	14	64	108	32	191	158	33	14	63	123	250	1258
NHS Southampton CCG	23	168	6	66	103	37	144	143	26	9	54	88	172	1039
NHS West Hampshire CCG	55	553	26	184	306	90	465	333	54	41	189	250	698	3244
Wessex	270	2561	141	947	1417	462	2261	1853	359	156	843	1453	3536	16259
% of all cancers (Wessex)	1.7%	15.8%	0.9%	5.8%	8.7%	2.8%	13.9%	11.4%	2.2%	1.0%	5.2%	8.9%	21.7%	
England Total (all cancers) 281335	4735	42567	2873	16970	24265	8953	37105	38690	8140	2806	11321	25791	56836	281052

2012 incidence: www.cancertoolkit.co.uk/Charts/Incidence/SingleYearCCG

5.3.3.2 Outcomes

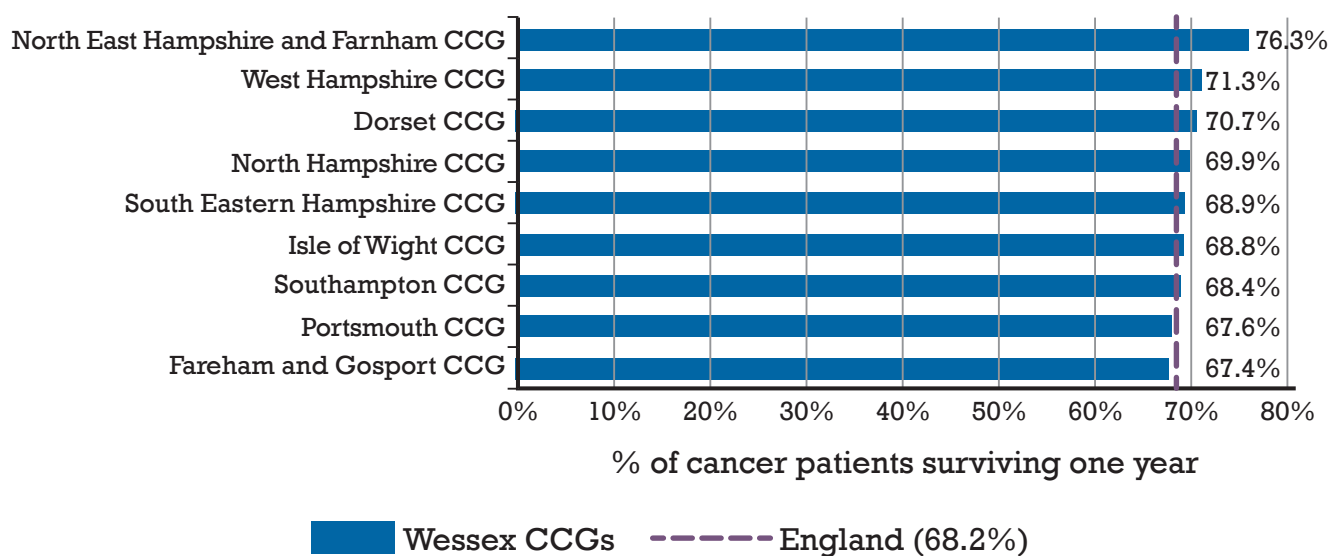
5.3.3.2.1 Survival

In line with the England trend, 1 year survival rates for Wessex have been improving slightly for all cancers and remain just above the English average, with 71.3% of patients (when considering all cancers diagnosed) surviving at least one year post diagnosis in 2011 (most recently available figures). This can be seen in the chart below.



There is variation across Wessex, with North East Hampshire and Farnham CCG having the highest one year survival rate at 76.3% whereas Fareham and Gosport CCG have the lowest at 67.4% in 2011, as shown below. Seven out of the nine CCGs have one year survival rates which are better than the English average. Caution should be taken when comparing across CCGs as variation may be due to multiple factors, including differences in case mix.

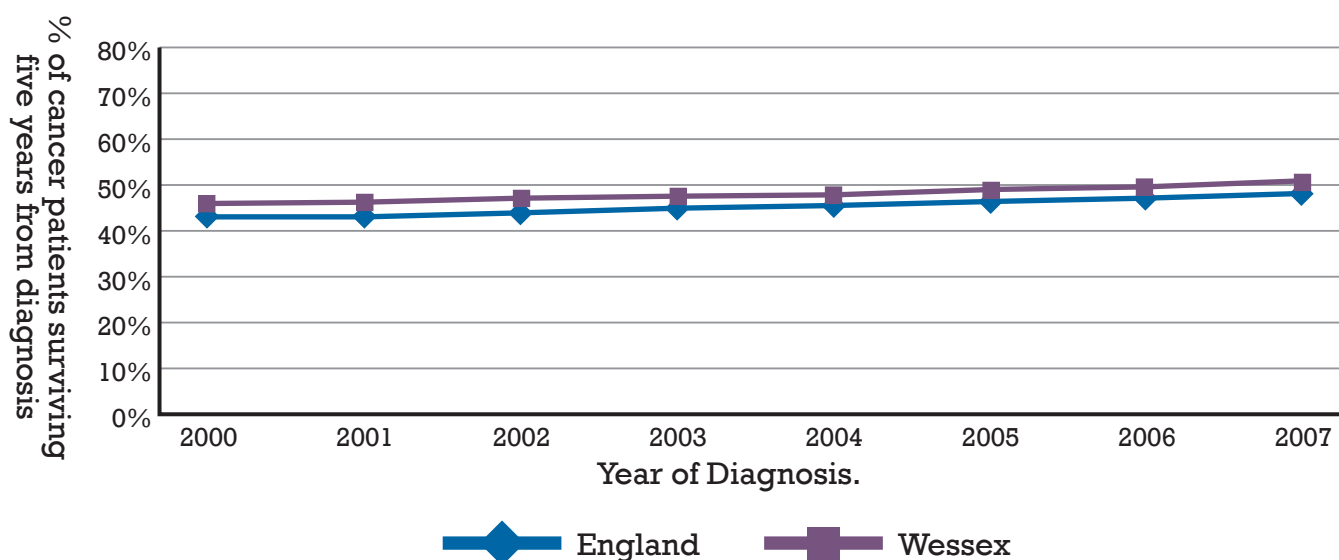
1 Year Cancer Survival Estimates by CCG 2011



Source: Cancer Commissioning Toolkit, NCIN

Although five year survival rates are lower, they follow a similar improving trend with Wessex just above the English average, as indicated in the chart below.

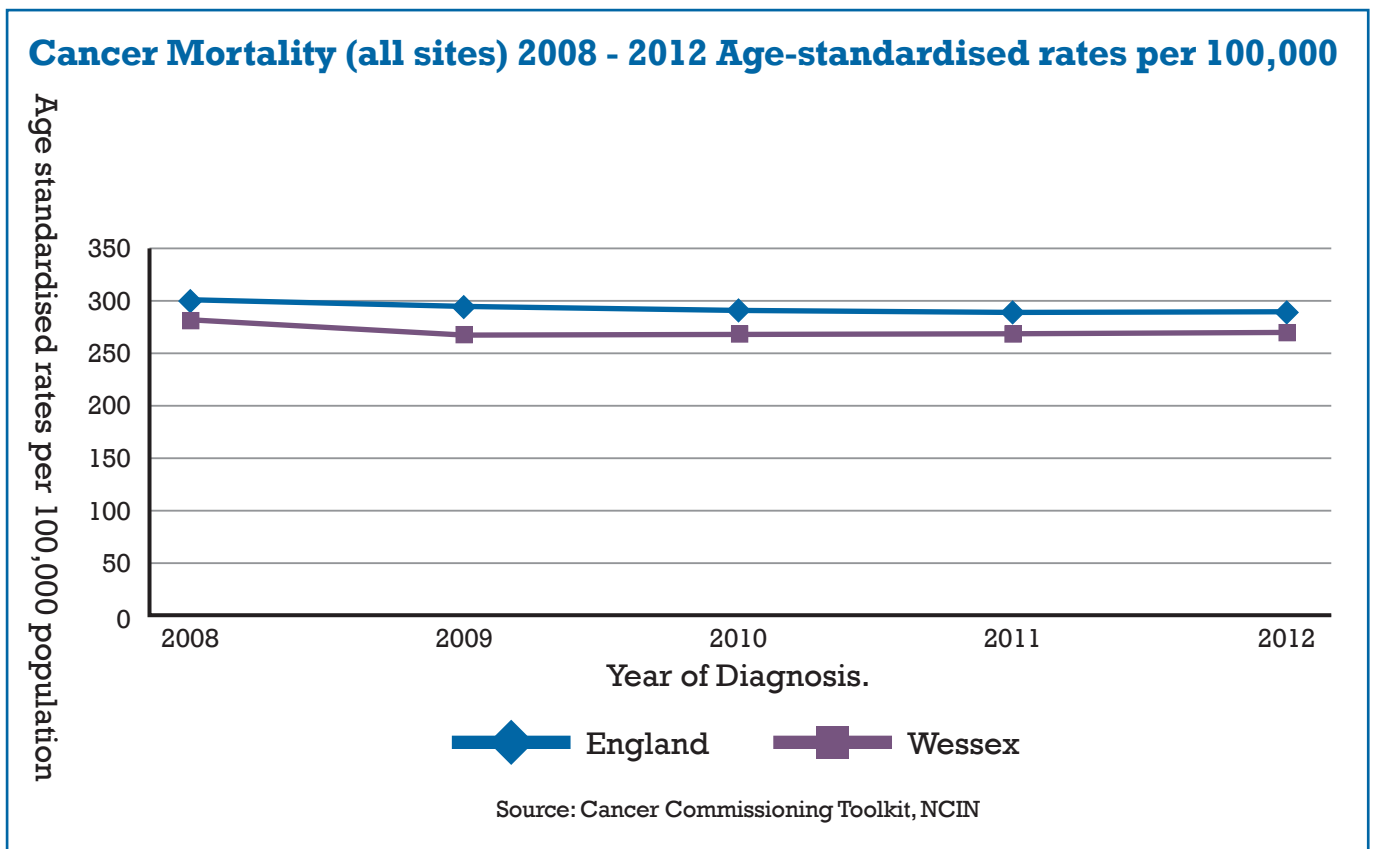
5 Year Cancer Survival Estimates 2000 to 2007



Source: Cancer Commissioning Toolkit, NCIN

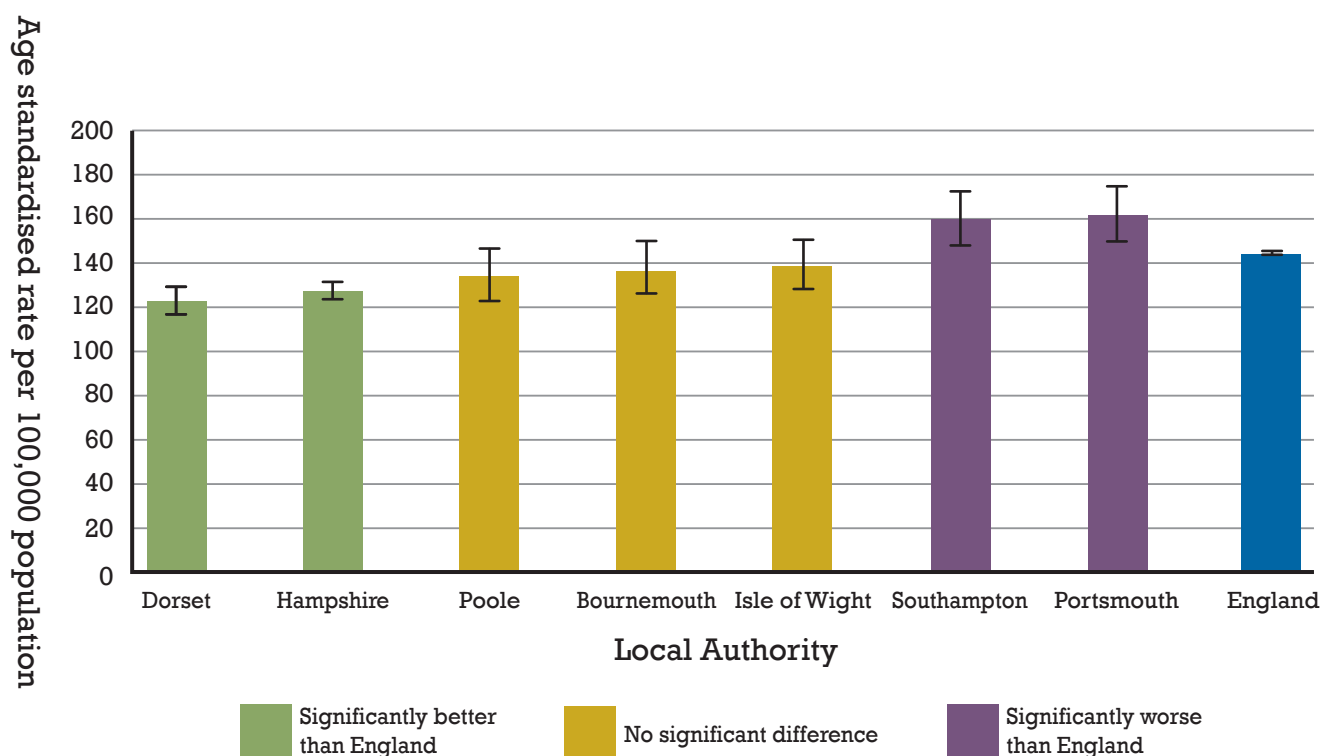
5.3.3.2.2 Mortality

Wessex also compares favourably with England in terms of mortality, but improvements in mortality appear to have levelled off.



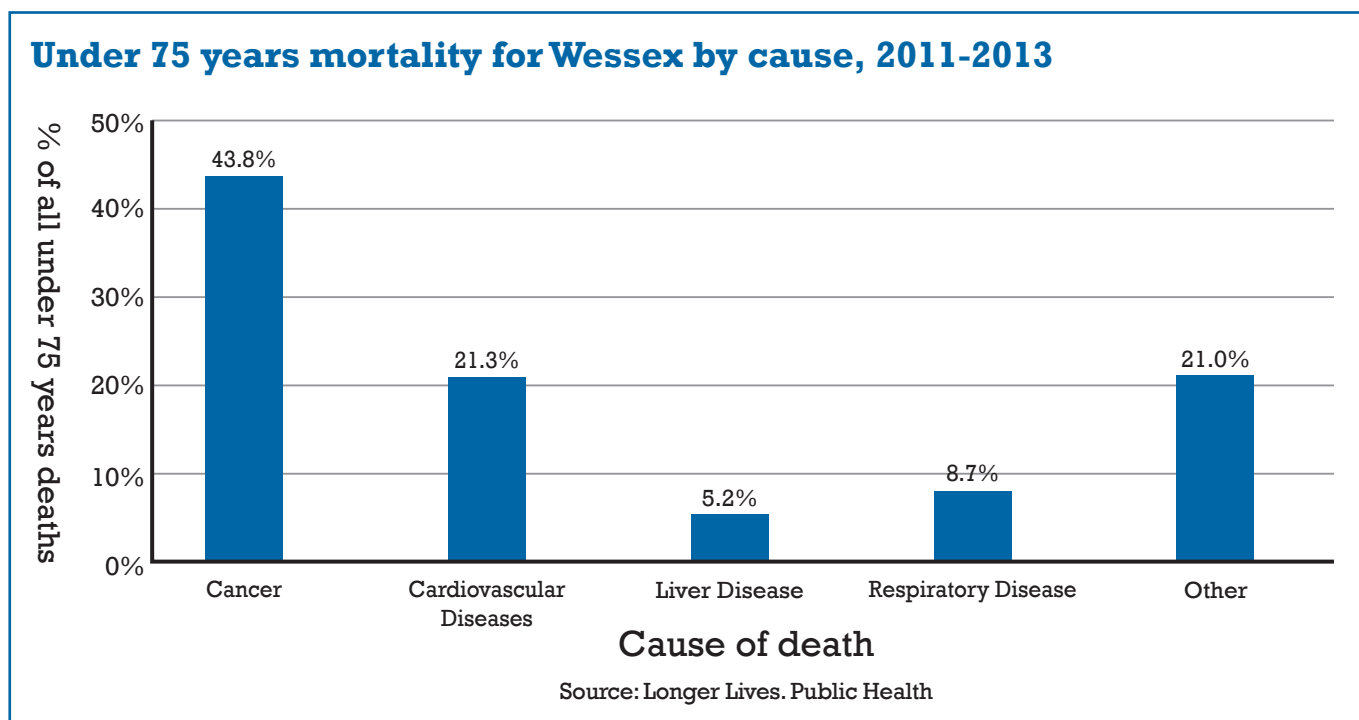
A substantial proportion of the cancer mortality figures are due to premature death (under aged 75 years). As the chart shows below, mortality rates for this age group vary across Wessex with both Portsmouth and Southampton having rates significantly higher than the England average, at 161.8 and 159.9 per 100,000 population respectively.¹⁹

Under 75 years mortality rate from cancer by local authority, 2011-13



Source: Public Health Outcomes Framework, PHE¹⁹

Cancer is by far the biggest cause of death in under 75 year olds, as indicated by the chart below.



Across Wessex, a large proportion of these deaths (56.7%) are considered to be preventable, i.e. all or most deaths from that cause could be avoided by public health interventions in the broadest sense. The proportion is above 50% for all local authorities during 2011-13 and ranges from 55.2% in Hampshire to 59.8% in Southampton.¹⁹

This stark reality perhaps offers the greatest opportunity for reducing mortality from cancer for commissioners, and its importance must not be underestimated.

Ambition 1

Over the next five years cancer survival in Wessex will continue to exceed the England average, and will improve by 5% across all cancers, from 14/15 baseline.

6. Underpinning quality principles

Good cancer care in Wessex is defined as achieving the best possible health and wellbeing for patients living with and beyond cancer, with particular reference to:

1. the timeliness and accuracy of diagnosis
2. efficacy and accessibility of treatments and
3. relevance and clarity of personalised care planning

Four principles underpin good cancer care:

1. Risks are identified early and accurately, dealt with effectively, employing current, evidenced interventions and the population are supported to proactively manage their own cancer risks.
2. Clinicians are at the forefront of commissioning and ongoing service improvement, and provide multidisciplinary, evidence-based leadership to disease and site specific pathway developments.
3. Excellent services are accessible equitably across the area of Wessex, ensuring parity for all the population in detection and treatment, and support for people living with cancer and those who support them.
4. Both health and wellbeing outcomes are monitored and measured against standards with a view to their maintenance and improvement.



7. Prevention

N.B. To reduce repetition, we have included cancer screening in this section, although recognise that screening is also a key part of early detection.

Prevention is the top priority for cancer – this requires a whole pathway approach



We must make our priority prevention.¹¹

Comment from a professional.



7.1 Key recommendations



Lifestyle factors Commissioners and providers should:

- Extend both general and targeted smoking cessation services for:
 - high risk populations and workplaces
 - people who have had cancer and/or existing comorbidities
 - people with serious mental illness
- Commission healthy lifestyle information/education provision with specific targeting based on population demographic and risk factors
- Influence healthy eating in childhood and beyond
- Support targeted sun-sense campaigns for high risk populations
- Commission weight management and weight loss services
- Ensure providers utilise every opportunity to share prevention messages in all interactions with patients

Screening Commissioners and providers should:

- Support NHS England Public Health Commissioning Team to improve the quality of screening programmes and reduce variation in coverage between GP practices

Genomics Commissioners and providers should:

- Ensure genetic counselling and testing services are available and accessible for eligible populations
- Ensure services are commissioned equitably for those identified as at high risk of developing future cancers.

Health Education and Workforce Commissioners and providers should:

- Ensure that the specialist skills and competencies that a Health Trainer has are maintained as local service developments re-configure a range of lifestyle services into integrated health and wellbeing hubs.

7.2 Context: national and local strategies, policy and how this relates to our population

THE EUROPEAN CODE AGAINST CANCER⁷

12 ways to reduce your cancer risk

- 1** Do not smoke. Do not use any form of tobacco.
- 2** Make your home smoke free. Support smoke-free policies in your workplace.
- 3** Take action to be a healthy body weight.
- 4** Be physically active in everyday life. Limit the time you spend sitting.
- 5** Have a healthy diet:
 - Eat plenty of whole grains, pulses, vegetables and fruits
 - Limit high calorie foods (foods high in sugar or fat) and avoid sugary drinks
 - Avoid processed meat; limit red meat and foods high in salt
- 6** If you drink alcohol of any type, limit your intake. Not drinking alcohol is better for cancer prevention.
- 7** Avoid too much sun, especially for children. Use sun protection. Do not use sunbeds.
- 8** In the workplace, protect yourself against cancer-causing substances by following health and safety instructions.
- 9** Find out if you are exposed to radiation from naturally high radon levels in your home. Take action to reduce high radon levels.
- 10** For women:
 - Breastfeeding reduces the mother's cancer risk. If you can, breastfeed your baby.
 - Hormone replacement therapy (HRT) increases the risk of certain cancers. Limit use of HRT.
- 11** Ensure your children take part in vaccination programmes for:
 - Hepatitis B (for newborns)
 - Human papillomavirus (HPV) (for girls).
- 12** Take part in organized cancer screening programmes for:
 - Bowel cancer (men and women)
 - Breast cancer (women)
 - Cervical cancer (women).



We recommend that the Wessex health economy and individuals endorse and implement the European Code Against Cancer above.

7.2.1 Primary prevention

The World Health Organisation (WHO) recognises that: **“Prevention offers the most cost-effective long-term strategy for the control of cancer.”**³

This is reflected in the NHS Five Year Forward View.⁸

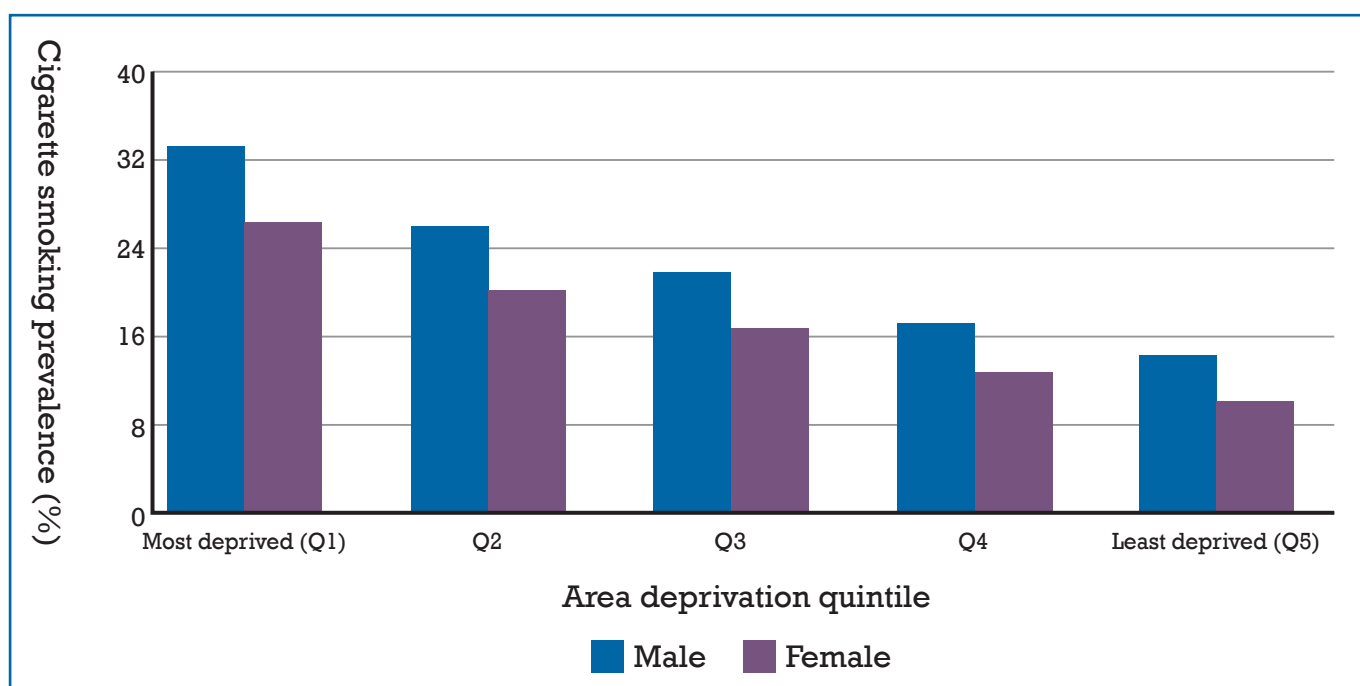
Smoking is the cause of 19% of all cancer cases⁴ - other lifestyle factors (alcohol, diet, exercise and excess weight) cause 32% of all cancer cases.⁵ All these factors may be subject to a deprivation gradient. Research indicates that people with serious mental illness are 2.6 times more likely to develop cancer than the general population.⁶

The WHO recognises prevention to be a very effective way to control the impact of cancer both from health and economic perspectives. This is true at any stage of the economic cycle but particularly in a financially challenged time. “Tobacco use, heavy use of alcohol, and obesity are most effectively prevented through a combination of education and social policies that encourage healthy behaviours and discourage unhealthy practices.”²⁰



7.2.1.1 Smoking


Smoking is the single largest avoidable cause of cancer. It is responsible for approximately 90% of all cases of lung cancer, and is the cause of around a quarter of all cancer deaths being a causative factor in at least 14 different types of cancer. There is a significant deprivation gradient.⁴



Accessible smoking cessation services should be an absolute priority. In Wessex, Southampton has the highest lung cancer incidence, closely followed by Portsmouth, Gosport and Rushmore, which is aligned to higher cigarette smoking prevalence in these areas.²¹ Smoking cessation services should be tailored to the specific needs of those most at risk (for example people with mental health issues). Given the level of priority, smoking cessation already has a number of area wide programmes underway. Commissioner and providers of both physical and mental health services must ensure smoking cessation remains a top priority.

7.2.1.2 Alcohol

Alcohol accounts for 23,300 cases of cancer in the UK per year.²² 11,000 cases of breast cancer are attributed to alcohol each year. Education should be delivered through schools, particularly simple messages, for example, that there is no 'safe' level of alcohol drinking, but the risk of cancer is lower the less alcohol you drink. There may be opportunities to have input into the school curriculum (e.g. PHSE lessons).



Local programmes, including the Academic Health Science Network programme aimed at reducing harm from alcohol, will provide evidence and resources to enable an area wide approach to reduce alcohol consumption.

7.2.1.3 Obesity

Approximately 22,000 cancer cases in the UK each year could be prevented through people maintaining a healthy weight.²² This is a complex area to address and will require collaboration across all agencies. The present generation of children and adults has higher levels of obesity beginning during infant and childhood years than any previously.

Support of pregnant mothers to address maternal obesity would lead to a reduced risk of both gestational diabetes and subsequent childhood obesity.

7.2.1.4 Diet

Access to fruit, non-starchy vegetables and fibre has a significant impact on cancer risk. Low levels of intake of these three dietary elements combined are associated with 30,000 cancer cases per year in the UK.²²

7.2.1.5 Exercise

The impact of exercise on cancer risk reduction is significant; over 11,000 cancer cases a year could be prevented if the population as a whole increased levels of exercise.²²

7.2.1.6 Ultraviolet light exposure/skin cancer

Wessex has one of the highest rates of melanoma in the UK.²³ Health promotion (e.g. sun-sense campaigns) should remain a priority. The prohibition of underage use of sunbeds should be rigorously enforced.

As the number of people who take immune suppressants increases as a result of successful organ transplantation, the numbers of malignancies linked to their treatment are also increasing. Skin cancers are a particular challenge in this group, and these patients require targeted advice, monitoring and treatment.

7.2.1.7 Infection

Human Papilloma Virus (HPV) is known to cause almost all cervical cancer. It can also be a causal factor in some cancers of the mouth, throat, vulva, vagina and anus. Current UK policy is to immunise all school age girls. Consideration should be given to extending this to boys, as was done for rubella. This would be effective at reducing prevalence of HPV in the community.

7.2.1.8 Familial/genetic predisposition

A minority of cancers, estimated to be between 5% and 10%, may be due to a familial gene link.²⁴ NICE guidelines exist which outline the best practice for genetic counselling and testing for people who are considered at high risk based on family history. However, we would anticipate that these recommendations based on research²⁵ may widen as more is learned about this area of medicine. Support is required for people identified as high risk in consideration of prophylactic treatment options.

7.2.1.9 The use of aspirin to prevent cancer

A number of studies have described the use of aspirin as a potential preventative measure against cancer.^{26, 27} However additional research is required²⁸ to provide generalised advice and guidance. Work is underway to develop patient information sources to support individualised decision making about the potential benefits.


7.2.2 Screening - in prevention and early detection

Cancer screening is a priority. NHS England is responsible for commissioning screening programmes.

7.2.2.1 Current screening programmes

The cervical screening programme aims to detect and treat early cell changes which could go on to develop into cancer if left untreated. Coverage is declining nationally and some national pilots are underway to look at the effectiveness of different approaches to addressing this. Coverage in Wessex is above the national average, although following the national trend and declining, falling just below the national target of 80% for the first time in some areas. There is considerable variation in coverage between GP practices within CCGs and between similar GP practices.²⁹ Key priorities are to ensure ease of access to screening appointments and to reduce variation in cervical screening between GP practices.

The breast cancer screening programme coverage for Wessex (aged 50-70 years) is above the national average and the national minimum standard of 70%. There is current variation within Wessex, with two of our CCGs not currently meeting this standard.³⁰ Wessex should aim to meet the minimum standard in every practice for this and all screening programmes, for as long as efficacy is endorsed by NICE.



The bowel cancer screening programme aims to detect early pre-cancerous change, and early stage cancer, leading to interventions which prevent cancer developing, or enable earlier intervention. Bowel screening coverage for Wessex (aged 60-74 years) is above the national average, and minimum standard level of 60%, however there is significant variation within and between CCGs. The lowest uptake is seen in areas of most deprivation, where incidence rates are the highest. However, even in areas of similar deprivation, wide variation is seen.³¹ The current pilot running in Wessex (Wessex Cancer SCN and Guildford Bowel Screening Hub collaboration) has the potential to be rolled out nationally – and certainly it may be extended in the Wessex region if found to be effective.³²

7.2.2.2 Screening programmes for the future:



More screening opportunities should be made available together with an awareness programme for more cancers.¹¹

Comment from a professional.



Implications of three year pilots which are underway around HPV testing as the primary screening test for cervical disease rather than the current cytology test will need to be considered for service planning and patient information.

Changes to the screening programme to include Faecal Immunochemical Testing (FIT) and the roll out of Bowel Scope Screening (BSS) will have a significant impact on endoscopy demand. The SCN is leading on demand and capacity modelling in partnership with the Academic Health Science Network, with results and recommendations for commissioners due in early 2015.

The implementation of CT lung cancer screening may need to be commissioned following pilots elsewhere in the country, if proven effective (pilot reports to be published June 2015).

The results of pilots for ovarian cancer screening are also due to report in 2015. If this proves to be clinically and cost effective, we will support roll out based on national service recommendations.

Local authorities may wish to consider vaccinating boys against HPV but national policy does not currently support this. NHS England, which currently commissions HPV vaccination in girls, will implement vaccinations for boys if national policy changes and this is included in the Section 7A agreement.

There is no current plan to roll out a national screening programme for prostate cancer, although this is being kept under close review as further evidence is compiled around methods which may be able to detect indolent and aggressive disease. Men over 50 years of age currently have the option to access Prostate Specific Antigen (PSA) testing from their GP.

We received a number of patient comments around prostate cancer screening and testing, a selection of these can be seen below:

“

P.S.A. testing has its weaknesses, but I and many other men have had their lives saved by insisting that their GPs carry out this simple blood test. I believe that all men should have the right to this test at an earlier age than currently provided and have more information about the availability of testing.¹¹

”

“

If GPs stuck to the existing protocol (as per NHS Choices website) on granting men aged 50+ their entitlement to a PSA test, more prostate cancers would be detected whilst they were still curable. The Prostate Cancer Risk Management Programme (PCRMP) is absolutely clear about a man's right to this test.¹¹

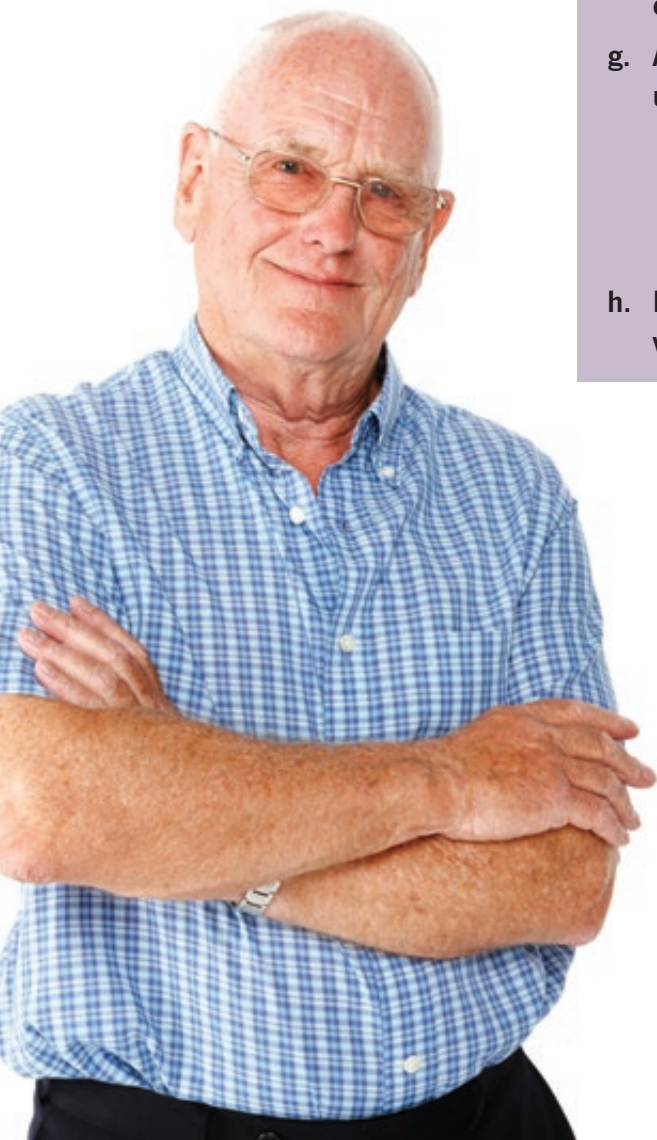
”

Strategic workforce planning and training needs to include preventative and screening services to ensure there are sufficient trained, competent staff in relevant specialties such as endoscopy and radiology.

7.2.3 Secondary prevention

There is strong evidence that cancer patients who engage in regular exercise (e.g. 150 minutes per week) have significantly lower recurrence rates of breast,³³ colorectal³⁴ and prostate³⁵ cancers. Other health benefits are seen; one such trial showed that the women having treatment for early breast cancer who took part in an exercise scheme had fewer contacts with both primary and secondary care and reported significant improvements in general wellbeing.³⁶

Ambition 2



Prevention by 2020:

- a. Smoking prevalence in Wessex at age 15 years will be below the national average
- b. Smoking prevalence in adults in Wessex will be below the national average
- c. Parity of smoking cessation between the wider population and people with a serious mental illness for the Wessex population
- d. Aggregate % of all adults achieving at least 150 minutes exercise per week above the national average (currently 55%)
- e. Aggregate % of adults classified as overweight below national average (currently 64%)
- f. All healthcare provider settings to be aware of and endorse the European Code Against Cancer recommendations for cancer prevention
- g. All practices will achieve at least the national minimum uptake for all cancer screening programmes, currently:
 - 60% for bowel cancer
 - 70% for breast cancer
 - 80% for cervical cancer
- h. Every practice in Wessex will achieve at least the 90% HPV vaccine target

8. Early awareness, early detection

N.B. To reduce repetition, we have included cancer screening in the prevention section, although recognise that screening is also a key part of early detection.

Earlier diagnosis of cancer should be a top priority for both commissioners and providers alike. After prevention, early detection is the most effective tool against premature mortality from cancer and enables the most economically viable of treatment options.

8.1 Key recommendations

Awareness Commissioners and providers should:

- Continue to support national cancer awareness and early diagnosis public campaigns, planning commissioned and provider capacity
- Consider strengthening cancer awareness at a local level, based on targeted population based initiatives
- Support primary care education programmes to enable clinicians to recognise and promptly act on early signs of cancer

Access Commissioners and providers should:

- Support providers in effective use of the Two Week Wait referral pathway and consider system re-engineering
- Consider development of improved communication pathways between GPs and specialist clinicians to access advice and guidance

Diagnostics Commissioners and providers should:

- Consider multi-professional review of diagnostic pathways and service provision to identify potential improvements
- Review whole care pathway access to diagnostic testing to enable most efficient care provision, both from patient and financial perspective
- Use contractual levers to improve performance along the diagnostic pathway
- Commission the Royal College of Radiologists and Royal College of General Practice recommendations to achieve the optimum reporting time for diagnostic tests

Workforce Commissioners should continue close collaboration with Health Education Wessex and the Local Medical Council (LMC) to support future workforce planning both in primary care and diagnostic services.

8.2 Context: national and local policy

The NHS England 5 Year Forward View, 2014, describes that **“Cancer survival is below the European average, especially for people aged over 75, and especially when measured at one year after diagnosis compared with five years. This suggests that late diagnosis and variation in subsequent access to some treatments are key reasons for the gap.”**

“...If we are able to deliver the vision set out in this Forward View at sufficient pace and scale, we believe that over the next five years, the NHS can deliver a 10% increase in those patients diagnosed early, equivalent to about 8,000 more patients living longer than five years after diagnosis.”⁸

Early awareness and early detection has been a national priority for several years. Cancer Research UK and Macmillan fund GP sessions across Wessex to engage with providers, commissioners and GPs. Primary Care engagement has proved to be very effective in changing professional behaviour and in doing so improving both detection and conversion rates. Referral pathways have significantly improved: nationally there has been a 50% increase in suspected cancer referrals since 2009/10, although this has created a capacity challenge for many providers.¹ Further pressure is anticipated in June 2015 if the (currently draft) NICE guidance to reduce conversion rates of GP cancer referrals to 3% is implemented.

8.3 Context: national and local demographics

Recent data has shown that cancer one year survival rates are improving across several cancers:³⁷

	2004	2012
Breast	94.3%	96.4%
Colorectal	69.5%	77.7%
Lung	26.6%	36.3%
Ovarian	65.7%	74.7%
Prostate	92.1%	96.6%

One year survival has been seen as a proxy for earlier diagnosis – this suggests that early diagnosis has been improving. Practice Cancer Profiles have also shown that across England the proportion of cancers diagnosed via the 2 week pathway has increased from 42.9% in 2010 to 47.7% in 2013.³⁸

8.4 The case for change-what this means for Wessex

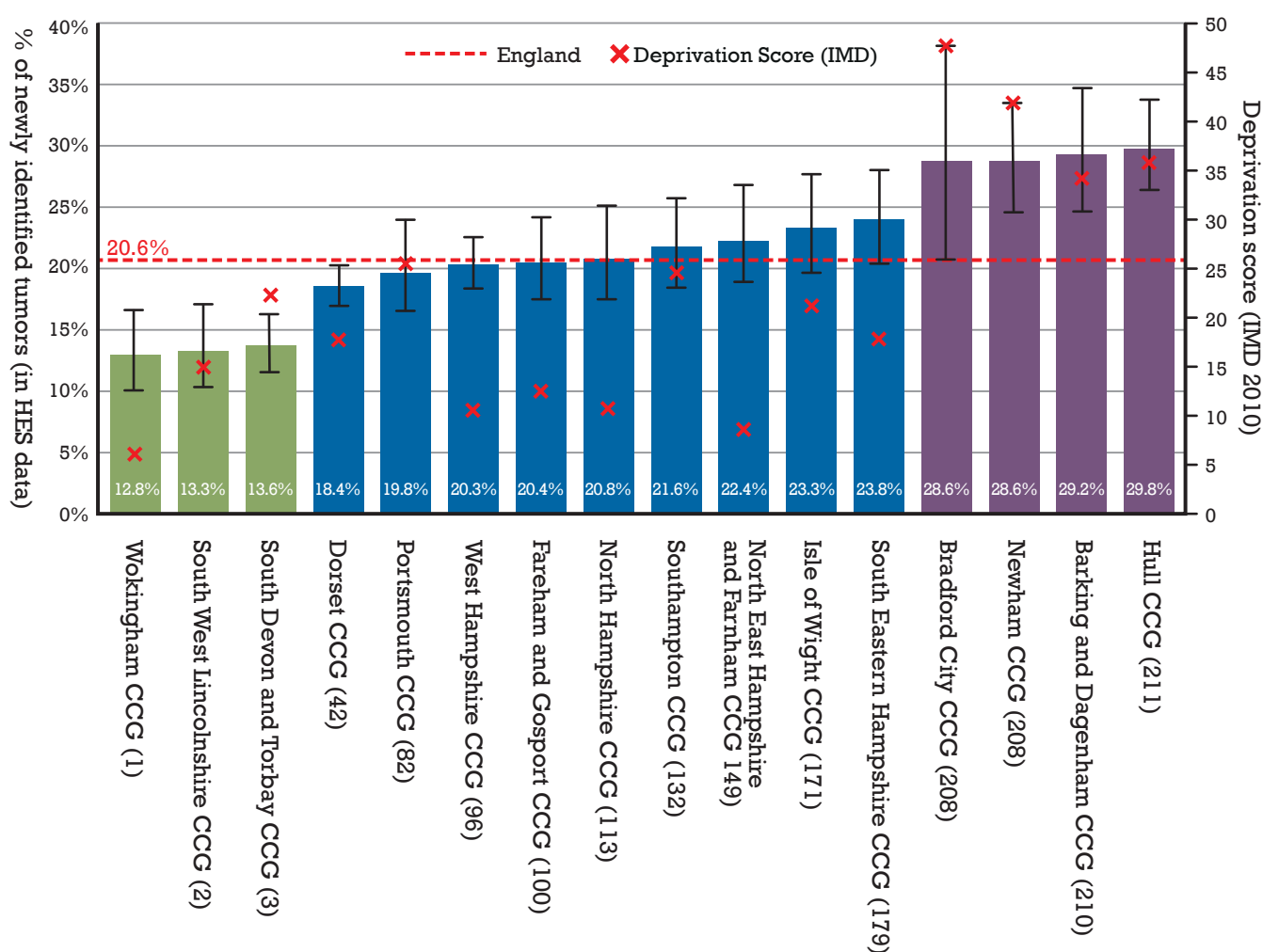
8.4.1 What are we doing well?

- The 1 year index of survival for all cancers by CCG is highest for NHS North East Hampshire and Farnham CCG, and the 5 year index of survival for all cancers for Wessex is higher than the England average.
- Trusts are achieving national standards for cancer waiting times, although this remains a challenge for providers.
- The success of the Cancer Primary Care engagement model developed by the previous cancer network is due to be rolled out and adopted across other clinical areas.

8.4.2 What do we need to focus on?

- Waiting times - Wessex, in line with the national picture, is currently facing challenges in delivering cancer waiting time standards. Specific areas of focus are the lung and urology diagnostic pathways.³⁹
- Emergency presentations – The graph below displays the percentage of cancers which are diagnosed following an emergency presentation for each CCG within Wessex and how these compare to the three lowest and highest values nationally. There is some variation within Wessex and there is room for improvement across the patch. The chart also demonstrates that, contrary to what one might expect, areas of high deprivation do not necessarily have high rates of emergency presentations.

Cancer emergency presentations and deprivation by CCG, July to December 2012 Lowest 3 values nationally, Wessex CCGs and highest 3 values nationally



Source: National Cancer Intelligence Network -
 Cancer Commissioning Toolkit, Deprivation Scores from the PHE General Practice Profiles
 Figures are based on Inpatient Hospital Episode Statistics (HES) data and are the proportion
 of tumors that first presented as an emergency to secondary care.
 Figures in brackets after the CCG name refer to the ranked position of the CCG's emergency presentations value.

To effectively diagnose cancer earlier, we need to employ whole system approaches. Key elements to success are combining the following programmes:

8.4.2.1 Public awareness and action on signs or symptoms

“

Some cancers require more awareness to be shown to the public at GP surgery level. Since my personal diagnosis several attempts have been made to get information leaflets displayed at the surgery with limited success. Care and treatment however has been exemplary from both GP Surgery and Hospital.¹¹

Comment from a patient

”



We would support the roll out of high quality patient self-assessment symptom analysis systems, for example web-based tools and applications, which relate to the way people are likely to seek information and advice.

The draft NICE Guideline “Suspected cancer: recognition and management” (November 2014)⁴⁰ is based on common potential symptoms of cancer, leading to explicit referral recommendations when a threshold for risk of cancer (>3% positive predictive value: currently 5%) is reached.

8.4.2.2 Initial assessment of cancer risk

Most people access their GP for advice once they identify symptoms. However, we know that many cancers are not diagnosed through a suspected cancer referral, and that some people have experienced a number of GP attendances before being referred and/or diagnosed.^{41,42} We know that too many cancers are still diagnosed as a result of emergency admissions, particularly those with less obvious symptoms.⁴² There is scope to make improvements to all pathways.

“

GPs should in a lot of cases send patients to see consultants earlier to try to prevent serious surgery.¹¹

Comment from a patient”

“

We should make a fundamental change to the way in which GPs have access to imaging. Resources should be directed to radiology to enable the full range of imaging to be available to GPs. This needs to be planned carefully, and radiology needs to be adequately staffed and supported to provide a better level of service. The old fashioned barriers between radiology/CT/MRI/scans and GPs need to go and so does the way in which radiology departments are funded.¹¹

Comment from a professional”

As referral thresholds for suspected cancers via the 2ww pathway may be lowered, demands on the diagnostic pathways will increase. This will lead to a reduction in treatment costs, with the exception of lung cancer.⁴³

8.4.2.3 Onward referral

It is 20 years since the Calman-Hine report⁴⁴ started highly organised, quality cancer care in the UK. Some pathways now could benefit from revision. Two examples relating to the initial diagnostic process are:

8.4.2.3.1 Access to diagnostics

A number of pilots are underway under the ACE (Accelerate, Coordinate, Evaluate) programme to increase primary care access to diagnostic services. If successful there will be the opportunity to adopt these on a nationwide basis.

There is emerging evidence that there is a strong correlation between the ease of GPs accessing advice from consultants and early diagnosis. It should be possible to improve existing telephone or electronic communications access for each cancer speciality.

There are currently two primary care Clinical Decision Support Tools under development. One is based on the Q-Cancer software – the other on the Risk Assessment Tool. These will be embedded in the Primary Care IT systems, and will generate a positive predictive value that a patient has cancer on the basis of a matrix of history, findings and laboratory results. This should enable earlier referrals. This will enable the draft NICE Guideline “Suspected cancer: recognition and management” (November 2014) to be implemented.⁴⁰

8.4.2.3.2 Specialist assessment and decision-making

Optimising the efficiency and quality of the referral process from primary to specialist assessment must be prioritised. 1,200,000 Two Week Wait referrals are made annually by the 36,000 General Practitioners in England and Wales.³⁸ A project to re-engineer the Two Week Wait referral system, specifically aimed at reducing the delay to first outpatient consultation from 14 days to 7, improving primary and secondary care dialogue and reviewing guidelines for 2ww criteria based on the new NICE guidance should form an early part of the CCG strategy for improving the quality of initial diagnosis of cancer.

Ambition 3

- a. The proportion of patients presenting as an emergency with a new cancer diagnosis will be below the England average across all nine CCGs in Wessex, aiming for an aggregate figure of 15% by 2020
- b. The proportion of patients diagnosed with early stage (stage 1 and 2) disease will improve by 20% across Wessex from around 50% currently

9. Treatments for the best outcomes

9.1 Key recommendations

Access and equity: Commissioners and providers should be able to demonstrate that all patients diagnosed with cancer in Wessex are able to access evidence based, best quality treatment.

Best practice pathways: It is recommended that commissioners and providers consistently:

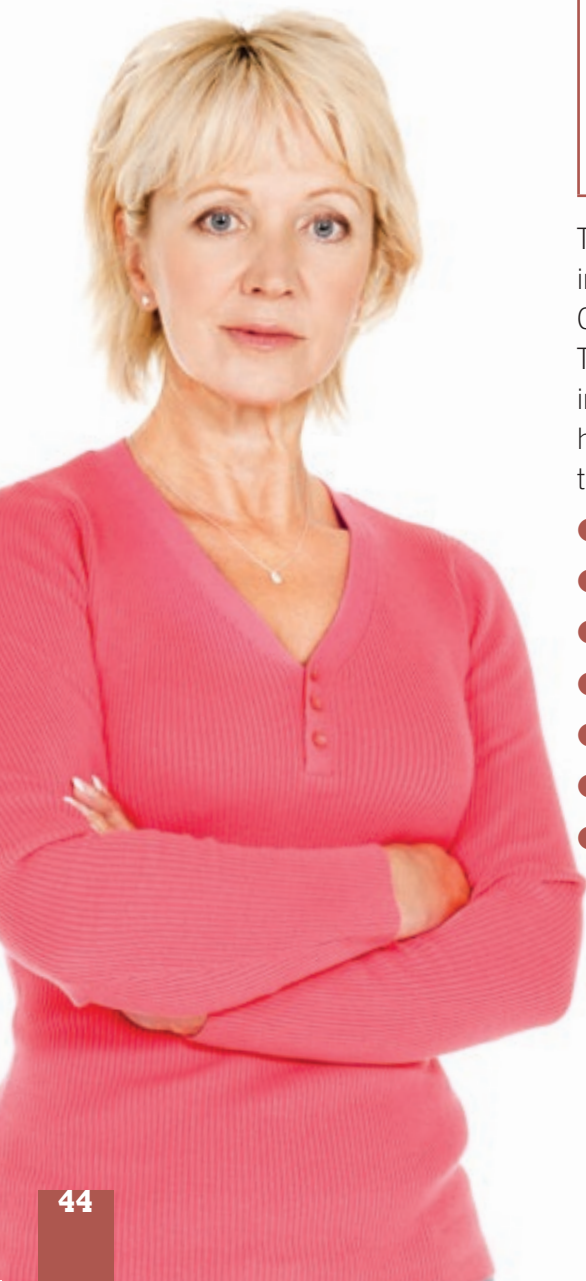
- Ensure Improving Outcomes Guidance (IOG) compliance through effective performance management of contracts
- Ensure that outcome data is readily available for all providers from the national Radiotherapy Dataset (RTDS), in order to inform commissioning decision making
- Consider how best to employ the data available in the Systemic Anti-Cancer Therapy (SACT) dataset to better understand the use of chemotherapy regimens across Wessex, particularly where variation in usage, cost and clinical effectiveness exist

Healthcare workforce: The healthcare economy support a joint SCN and Health Education (Wessex) programme to investigate potential future workforce models, to develop recommendations for optimal workforce resource, to benchmark against existing healthcare need, and to identify potential service change accordingly.

Service configuration: Commissioners and providers should engage directly with the cancer Site Specific Groups to inform and influence review of service specifications, and make recommendations for reconfiguration in cases where the specification is not yet met.

Personalised treatment and management: It is recommended that commissioners and providers:

- Support arrangements for the commissioning of genomic, genetic and molecular pathology services to ensure equity of access across the Wessex population
- Ensure treatment summaries are included in acute contracts, and pursue timely and meaningful cancer care reviews for all patients in primary care
- Commission development of combined geriatric and oncology teams to better assess and manage elderly patients with cancer



Enhanced recovery: It is recommended commissioners and providers:

- Commission along the best practice guidelines to reduce variation in surgical interventions, improving patient experience, outcomes and reducing cost, for example in colorectal surgery
- Ensure compliance of provider organisations with peer review metrics for Acute Oncology Service in order to increase quality of services

Patient experience: Commissioners and providers must ensure that patient experience is central to the delivery of high quality cancer services and should ensure that the National Cancer Patient Experience Survey is used systematically to improve service provision.

Accelerated adoption of technologies: Commissioners and providers should proactively engage in local partnership networks to identify innovation and resource and spread new ways of working across a wider health economy.

The principles behind delivering high quality cancer care are described in detail in the NHS Outcomes Framework,⁹ in Improving Outcomes: A Strategy for Cancer,¹⁰ and in NICE Guidelines covering specific diseases and technologies. The Cancer Strategic Clinical Network role is to identify gaps, areas where local implementation is stalled or at risk, or new developments in practice which have not been implemented. Key areas where the SCN can act to ensure treatments for best outcomes are delivered have been identified as:

- Access and equity
- Healthcare workforce
- Service configuration
- Personalised treatment and management
- Enhanced recovery
- Patient experience
- Accelerated adoption of technologies



9.2 Context - national and local policy

9.2.1 Access and equity

Inequalities in cancer outcomes are defined as “the differences between individuals’ cancer experience or outcome which result from their social-economic status, race, age, gender, disability, religion or belief, sexual orientation, cancer type or geographical location.”⁴⁵ It has been recognised nationally that access to services and wider inequalities often interlink. Cancer treatment options are not currently always provided equitably, even within the same locality, and additionally not all patients can access a range of options, particularly in relation to newer treatment modalities. This is due to a variety of factors, including commissioning issues, local clinical expertise, local investment, training, equipment, geography, patient choice and time lag in uptake of newer modalities.

National drivers to reduce this inequity include:

- national service specifications (based on national guidelines and clinical reference group input)
- national audits and service profile data publication which seek to highlight inequalities of service provision
- requirement for patients to have equitable access to a wider range of innovative and quality treatments (including radiotherapy) and services based on wider catchment populations based on quality standards⁴⁶

“

Best quality radiotherapy with equipment that is not too old, with reduced travel times.¹¹

Comment from a professional”

9.2.2 Healthcare workforce

Delivery of high quality cancer care, from the ability to identify and diagnose patients, to impart difficult information to newly diagnosed patients and delivery of complex, highly specialised care, rehabilitation and ongoing support, requires an adequate number of suitably trained, competent and motivated professionals and support staff. Increased patient numbers, broader, more complex treatment options, improved survival with cancer and increased patient expectations will all require review of the workforce required, and

planning to address how to address current and future gaps, if standards are to be maintained or raised.

“

More co-operation and joining together of secondary care and primary care services in the future (i.e. community based) as proposed by NHS England recent report (Five Year Forward View).¹¹

Comment from a professional

”

Currently there is a national shortage of oncology consultants. The Royal College of Radiologists has calculated that by 2018 there will be a shortfall of 370 WTE Consultants in Clinical Oncology. 540 GPs are due to retire in the next two years and the Wessex GP Scheme only trains 150 a year.⁴⁷ This shortfall may reduce availability of appointments and thereby delay the entry to the cancer treatment pathways. We know that there are also significant deficits in the number of Allied Health Professionals and clinicians particularly in Diagnostic Imaging and Histopathology.

“

Funding enough capacity to deal with rising numbers, more older patients and more treatments. Better treatments mean longer survival and even more treatments. As a consultant, we are struggling to cope with demand.¹¹

Comment from a professional

”

9.2.3 Service configuration

Recommended specialised service configurations are long established, based on historical patient flow, consultant specialised practice, and Improving Outcomes Guidance (quality assured and monitored annually through the National Cancer Peer Review process). Within Wessex there are a minimal number of specialised care pathways that are currently non-IOG compliant, which will need to be addressed during 2015.

9.2.3.1 **Wessex cancer centres:**

- Southampton General Hospital (University Hospital Southampton NHS Foundation Trust)
- Queen Alexandra Hospital (Portsmouth Hospitals NHS Trust)
- Dorset Cancer Centre (Poole Hospital NHS Foundation Trust)

9.2.3.2 **Wessex cancer units:**

- Royal Bournemouth Hospital (Royal Bournemouth and Christchurch NHS Foundation Trust)
- Dorset County Hospital NHS Foundation Trust
- St Mary's Hospital (Isle of Wight NHS Trust)
- Basingstoke and North Hampshire Hospital (Hampshire Hospitals NHS Foundation Trust)
- Royal Hampshire County Hospital-Winchester (Hampshire Hospitals NHS Foundation Trust)



9.2.3.3 Additional related patient flows and providers

- Salisbury NHS Foundation Trust
- St Richard's Hospital (Western Sussex Hospitals NHS Foundation Trust)
- Frimley Park Hospital (Frimley Health NHS Foundation Trust)
- Channel Islands

Some patient pathways for specialised services flow across network boundaries. We anticipate that the result of the national Specialised Services Commissioning service specification compliance exercise may make recommendations which would require configuration change in Wessex.



To preserve and develop the service on the Island, clear pathways must be commissioned and services seamlessly interlinked.¹¹

Services should be available to patients near their homes, especially when they are unwell.¹¹

Improved communication between hospitals with a view to accelerate pathways when patients are transferred for specialist care or testing.¹¹

Comments from Professionals



9.2.4 Personalised treatment and management

Increasingly treatment is being tailored to offer more personalised management. This describes a range of approaches which ranges from, and includes:

- Supported individual decision making about treatment options and choices
- Best use of clinical outcome data to inform clinicians and patients about likely potential outcomes based on age, comorbidities, health status
- A range of individualised options to manage ongoing care, for example via telehealth/online/web support
- Electronic prescribing systems to promote best practice, safety and medicines management
- Delivery of personalised medicine founded on molecular phenotyping/genotyping
- Specialised care for children, young people and the elderly

“

A huge amount of money in cancer care is being spent on 3rd/4th/5th line chemo often with little conversation about the likely response rate (and what is meant by ‘response rate’) with the patients. This needs to change both to help patients understand the likelihood of treatment being successful and to allow them to make decisions about future care. However also in order to reduce money spent on chemotherapy budget.¹¹

Comment from a Professional

”

It has long been recognised that children, teenagers and young adults have specific care needs related to a cancer diagnosis, and specific standards exist to support this.⁴⁸

Improving Outcomes, a Strategy for Cancer,⁴⁹ emphasises the need for cancer services specifically tailored for the needs of the elderly population, and indicates that a large gap exists between current provision and actual need. The lack of what might be termed Oncogeriatric services impairs quality of care for a large (and growing) group of patients whose specific needs require expert management. Failure to apply potentially lifesaving treatments based on age alone is discriminatory, and impairs cancer outcomes. Equally, inappropriate treatment in a patient group with metabolic and physical impairment is associated with adverse outcomes.

“

I think it will depend on the individual. The more the positive mental attitude the more willing the person to engage in initiatives. Therefore, decisions should be based around the individuals diagnosis and emotional needs.¹¹

Given the current economic climate it is important that treatment decisions are based on cost-effectiveness, rather than clinical effectiveness alone.¹¹

Comments from Professionals

”

9.2.5 Enhanced recovery

Enhanced recovery (ER) is a whole health system programme which prepares people for, and supports people to recover more quickly from planned interventions. It has been demonstrated to be safe, and improves outcomes and is cost effective. ER forms part of the national focus on delivering quality clinical pathways seven days a week, and as a concept, can support integration across the whole healthcare system. It is an approach that has full support of the Royal Colleges, who have committed to drive the delivery of ER as standard practice.⁵⁰ ER is well established across a number of cancer treatments, and now should be implemented consistently across the area. Commissioners should ensure that ER is a prerequisite for quality cancer pathways where applicable.

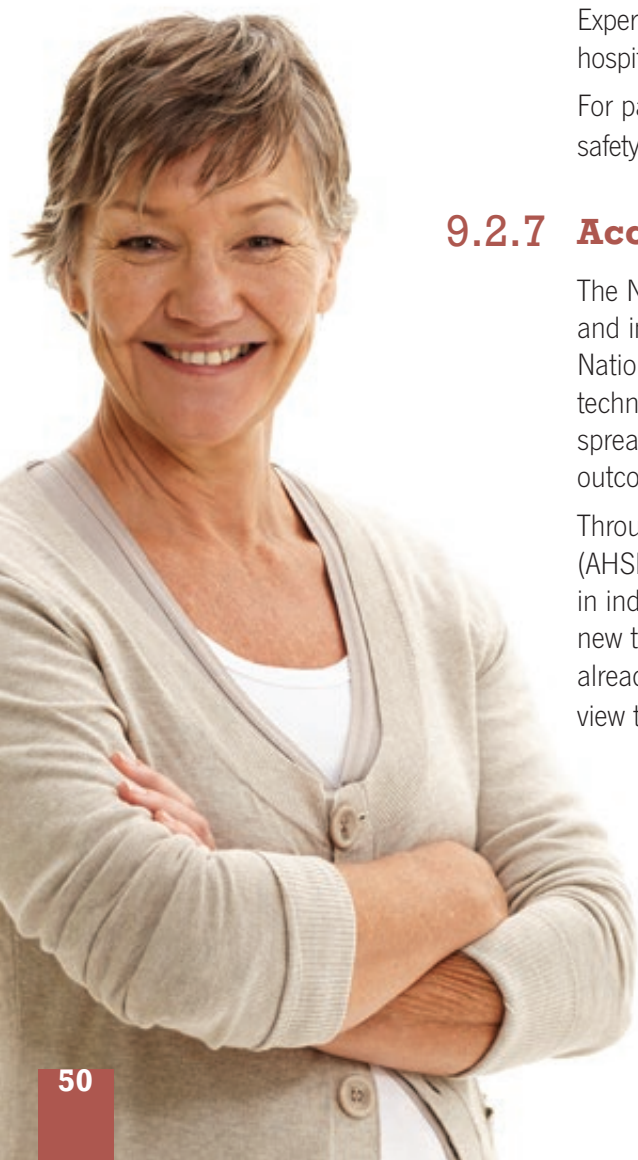
9.2.6 Patient experience

Each year more than 60,000 patients in England take part in a Cancer Patient Experience survey (CPES)⁵¹. In the most recent survey, published in 2014, local hospitals were included in the top ten most improved sites; but we can do more. For patients, experience of care is as important as clinical effectiveness and safety. Improved patient experience is strongly connected with patients' wellbeing.

9.2.7 Accelerated adoption of technologies

The NHS has traditionally been a leader of innovation, but the spread and implementation of new and novel technologies is slow and complex. Nationally there is a call to speed up the implementation and 'diffusion' of new technologies. The Royal College of Surgeons⁵² outline how innovations can be spread and adopted which can significantly improve patient experience and outcomes.

Through partnerships like the Wessex Academic Health Health Science Network (AHSN) local commissioners have the opportunity to link directly to innovators in industry and academic institutions and implement rapid application of new technologies and ways of working. The Strategic Clinical Network has already developed a number of programmes alongside the AHSN with a view to utilising this local partnership for rapid adoption across the area.





9.3 The case for change - what this means for Wessex

9.3.1 Access and equity

Patient pathways and protocols need to reflect uniformity and equity of access for patients, particularly regarding continuity of diagnostic care, access to research (both scientific and health services research), consistent use of language regarding patient information, and standardised data reporting systems.

Reporting times for diagnostic imaging vary across Wessex. In 2013, the Royal College of Radiologists and Royal College of GPs⁵³ published Quality Imaging Services for Primary Care: a good practice guide which sets out minimum turnaround times for reports.

Chemotherapy

Chemotherapy is increasingly successful as a treatment but is ever more expensive and complex. Accurate, timely and complete data collection is a priority for all cancer patients, both adult and paediatric, in acute inpatient, day-case, outpatient settings and delivery in the community. Cancer chemotherapy has been provided in the NHS for decades but no national mechanism for recording treatment existed until the Chemotherapy Intelligence Unit (CIU) launched the Systemic Anti-Cancer Therapy Dataset (SACT) in April 2012.

Wessex SCN recommends that commissioners should consider how best to employ the data available in the SACT dataset, to better understand the use of chemotherapy regimens across Wessex - particularly where variation in usage, cost and clinical effectiveness exist. This will be increasingly important if more chemotherapy is to be delivered closer to patients' homes.

E-Prescribing systems are in place across the Wessex geography; however commissioners must ensure the systems are fully operational for all disease pathways and achieve and maintain compliance with IOG standards to maintain patient safety.

Minimally invasive surgery

Minimally invasive surgery (MIS), or laparoscopic (keyhole) surgery, is a modern surgical technique in which operations are performed through small incisions (usually 0.5–1.5 cm). There are a number of advantages to the patient with laparoscopic surgery versus open surgery. Pain and blood loss are reduced, and hospital stay and recovery times are generally much shorter. The associated healthcare costs are frequently also lessened as a consequence of the reductions in inpatient stay, although consumables are costly. This is

particularly the case with robotically assisted surgery, which is becoming well established in the surgical treatment of some, especially pelvic, cancers.

It is likely that further centralisation of such surgery into higher volume centres will result from the ongoing specialised services review. It is our expectation that our cancer site specific groups will contribute to any decision making with respect to the future configuration of such surgical centres in Wessex. It is also our expectation that all patients in Wessex will be offered MIS where appropriate, and that open surgery only be employed where MIS is considered technically inappropriate. Cancer site specific groups will continue to modify patient pathways to reflect this.

Radiotherapy

Around 40% of cancer patients have radiotherapy as part of their treatment⁴⁶ - the 2011 Cancer Plan 'Improving Outcomes: a Strategy for Cancer' states "to improve outcomes from radiotherapy, there must be equitable access to high quality, safe, timely, protocol-driven quality-controlled services focused around patients' needs."¹⁰

Intensity modulated radiotherapy (IMRT) allows shaping of the radiation beams to closely fit the area of the cancer, thereby minimising side effects and improving outcomes. IMRT is currently used for around 25% patients receiving radiotherapy, but it is thought that up to 50% of patients could benefit from its use.⁴⁶ Image guided radiotherapy (IGRT) uses imaging during treatment to allow radiotherapy treatments to be tailored more accurately for individual patients, allowing real-time adjustments to take account of patient movement, breathing etc.

Stereotactic Body Radiotherapy (SBRT) is a combination of IMRT and IGRT to deliver a small number of very high dose treatments with curative intent. SBRT was first developed for brain tumours, and is now commissioned for early lung cancer in surgically unfit patients where local control is increased from about 30% to 80% with SBRT.

These innovations in radiotherapy technologies are not available equitably across Wessex, with significant variation between radiotherapy providers remaining. Both CCGs and Specialised Commissioning should work collaboratively with our radiotherapy providers to ensure that patients have appropriate and timely access to such technologies. NHS England will undertake procurement for these services and we consider that it should be exceptional that patients should need to travel outside the Wessex area for modern radiotherapy, for anything other than the rarest of indications.

Commissioners should ensure that outcome data is readily available for all providers from the national Radiotherapy Dataset (RTDS), in order to inform commissioning decision making.

9.3.2 Healthcare workforce

The Wessex Cancer SCN is working in conjunction with Health Education Wessex to support commissioners and providers to identify emerging workforce issues in the cancer workforce over the next decade.

Commissioners need to recognise the essential role of allied health professionals in enabling people to manage conditions, preventing worsening of a condition and improving outcomes.

“

Adequate access to specialist support services such as dietetic support and speech and language therapy.¹¹

Comment from a Professional

”

9.3.3 Service configuration

Nationally a small number of specialised cancer services are still to meet national service configuration recommendations. In Wessex, the Site Specific Groups will be responsible for review of service specifications, and making recommendations for reconfiguration in cases where the specification is not yet met.

There is a strong drive for commissioners to support care closer to home, where clinically effective and safe, to improve patients' experience. For cancer this is likely to relate to providing appropriate chemotherapy treatments and services in the community, closer to the patient's home.

Central to our strategic vision is our commitment to reduce inequalities. While recognising that some changes in specialised commissioning are anticipated, any future proposed changes to service configuration will have the access needs (socio-economical/ geographical and cancer type) of our population as a top priority.

9.3.4 Personalised treatment and management

Specific focus for the next 5 years will be:

- improvement of referral pathways
- reduction in unplanned hospital admissions for end of life care

Whilst these are all important for patient outcomes and patient experience, further work is needed to understand the impact for commissioners.

Wessex SCN could support pilot projects involving teams of specialist physicians, surgeons and oncologists in which elderly cancer patients are provided with assessment, support and treatment specifically tailored to their needs. Length of stay, discharge success, patient experience assessment, operative complications and ability to deliver timely post-operative oncology treatment will all be measured as markers of success.

The requirement for molecular phenotyping prior to cancer treatment is increasing rapidly year-on-year. When required, molecular phenotyping of patients in Wessex is undertaken in multiple different laboratories across the UK, without any standardisation or specification in terms of choice of test, choice of laboratory, cost-effectiveness, sample preparation and transportation, reporting mechanism or subsequent decision making processes.

Funding streams for molecular phenotyping are ill defined. There is no organised system for ensuring that costs are optimised, and this impacts 62 day pathway performance. Streamlining of the processes for molecular phenotyping, for instance by developing a Wessex-centred service, is likely to relieve pressures on the 62-day pathway, and also improve cost-effectiveness.

9.3.5 Enhanced recovery

Wessex surgical teams and providers have been leaders in Enhanced Recovery programmes and this has been successfully implemented in most Trusts. However, there may be further gains to make by sharing skills, approaches and experience across teams and Trusts, and the Site Specific Groups could provide a mechanism to support this. The next step will be to further involve patients and commissioners in co-designing quality, integrated pathways which are delivered seven days a week, and are not confined to acute based services.

9.3.6 Patient experience

Across Wessex, hospitals report comparatively positive patient experience, but there is variation both between hospital sites and cancer types. All the work to improve cancer services in Wessex must be driven by and evaluated by patient experience as much as clinical outcome.

9.3.7 Accelerated adoption of technologies

Drug innovation

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.



Molecular phenotyping

The uptake of validated and recommended molecular stratification tools which can aid treatment choices would be supported by the establishment of a Wessex-centred molecular phenotyping service, with specialist expertise and an understanding of local needs would lead to improved outcomes through greater uptake of cutting edge therapies, and more rapid throughput during the diagnostic process.

Ambition 4

- a. Within 5 years all patients will receive cancer care in Wessex on the basis of a personalised, evidence based treatment pathway designed to optimise both outcome and experience**
- b. No patient requiring cancer treatment using modern radiotherapy technologies, other than proton beam therapy, will need to travel outside Wessex for treatment unless as a result of patient choice**



10. Living with and beyond cancer

10.1 Key recommendations

Access: Commissioners and providers should ensure there is equitable provision and access to services on a seven day basis for those living with and beyond cancer across Wessex.

Recovery planning: All CCGs should implement the elements of the Recovery Package and integrate into contracts over the next 3 years as follows:

- Every patient should have a holistic needs assessment undertaken at least once. It is recommended by March 2016 that 50% of all patients will have a holistic needs assessment, increasing over the following 2 years to 100% by March 2018
- Treatment summaries are integrated into all CCGs contracts for 2015/2016 and 50% of all new patients receive at least one treatment summary during 2015/16, increasing to 100% by March 2018
- 50% of all new cancer patients will receive a care plan soon after diagnosis by March 2016, increasing to 100% by March 2018
- Cancer care reviews will take place in primary care following receipt of a treatment summary and care plan. It is recommended that 50% of patients will have a cancer care review by March 2016, increasing to 100% by March 2018
- Patients should have access to case management support and/or specialist services, for example for late effects of cancer treatment, or to assist with staying in or returning to work

Commissioners and providers should review stratified pathways of care recognising the dependency on having the elements of the recovery package in place to support alternatives to follow up and support.

Workforce: Commissioners and providers should ensure:

- Health professionals caring for people with cancer are able to demonstrate competency in supporting people living with and beyond cancer, and managing the consequences of cancer treatment
- Healthcare professionals are trained in behavioural change techniques, such as motivational interviewing, and a general awareness of the needs of those living with and beyond cancer





Health and wellbeing: Commissioners and providers should ensure:

- All patients should be offered health and wellbeing support, including support to return to work where appropriate at the end of primary treatment. It is recommended that 50% of providers will have introduced health and wellbeing events by March 2016, increasing to 100% by March 2018
- Where appropriate, all patients should be informed of the benefits of healthy lifestyle in preventing further cancer, and supported to make changes if needed
- All patients should have access to appropriate information including lifestyle and physical activity advice. This could be undertaken with patients with other conditions (e.g. cardiovascular disease)



Far more information and emphasis on self-care and self help, with signposting to alternative therapies and treatment. This will empower the patient and give the feeling of control. As well as being an NHS employee I have also experienced cancer twice. My first experience was one of complete rollercoaster and disempowerment. By the time I went through it the 2nd time I had done my research and found my own way by combining alternative therapies with conventional medicine and the experience was very different. I had taken control and felt able to challenge and discuss my treatment plan with healthcare professionals adult to adult. That said life would have been easier if the information/ideas were available at the hospital i.e. discussed with key worker or in the MacMillan Centres - I know they do have a lot of info and provide some sessions but the positive benefits of accessing these avenues are not really pushed. The idea of patients taking control and being empowered shouldn't be underestimated.¹¹

Comment from a Professional



10.2 Context - national and local policy

The Five Year Forward View highlighted the five year ambition for cancer. Reference is made to those living with and beyond cancer and recommends the importance of:

‘Work (undertaken) in partnership with patient organisations to promote the provision of the Cancer Recovery Package, to ensure care is coordinated between primary and acute care, so that patients are assessed and care planned appropriately. Support and aftercare and end of life care – which improves patient experience and patient reported outcomes – will all increasingly be provided in community settings.’⁸

Prevention is also a key feature of the five year forward view and, as such, it details the importance of secondary prevention which means that the public health of those living with and beyond cancer is as important to consider to help prevent and minimise other co-morbidities.

Professionals need to recognise the consequences of cancer treatments, and to ensure information and support is provided that enables people to manage the effects of treatment in the short and long term.⁵⁴ All health professionals should be able to demonstrate competence in supporting people living with and beyond cancer.⁵⁵

There is good evidence that physical activity can help in the prevention of cancer, reducing recurrence, reducing mortality and reducing side effects.^{56, 57} According to Macmillan Cancer Support, 150 minutes of physical activity a week, could reduce mortality for breast and prostate cancers by 30-40%, and for bowel cancer by up to 50%.⁵⁷

Local policy

Wessex Rehabilitation, Reablement and Recovery Quality Guidance Document,⁵⁸ which is applicable to all disease states and co-morbidities including cancer patients, was developed by the Wessex SCN and endorses the importance of movement out of hospital, accessing services and supported self-management.

10.3 Context - national and local demographics

Nationally the number of people living with and beyond cancer in 2010 was 2 million. This figure is set to double to 4 million by 2030.²

In Wessex there are 4514 people aged 75 years and over, living 15-20 years after diagnosis.⁵⁹



10.4 The case for change - what this means for Wessex

10.4.1 Recovery package implementation

Continue the development of a meaningful integrated cancer recovery package at the start of the patient's journey for all patients, supported by a robust implementation plan with clear measurable outcomes.

10.4.2 Risk stratified pathways

Implement stratified pathways for the follow up of cancer patients - The National Cancer Survivorship Initiative⁶⁰ recommends that, following initial treatment, all patients should be assessed for their risk of developing further disease or consequences of treatment. This will identify those patients who can safely self-manage their condition.

10.4.3 Access to services

Services for people living with and beyond cancer should be able to be accessed when required and have skilled and competent staff to support and/or signpost patients on to other services.

Specialist staff in secondary care should be enabled to support community and primary care colleagues with the vast majority of care following treatment.

10.4.4 Education, training and development of the workforce

Educate and promote awareness to commissioners, providers and patients of the issues facing patients living with and beyond cancer. Occupational therapists and other allied health professions such as physiotherapists, speech and language therapists, and dieticians will also have a key role in enabling patients to live with and beyond cancer. Wessex has one occupational therapist per 2,860 head of population and one physiotherapist per 3,695 head of population.⁴⁷ Occupational therapists and physiotherapists in Wessex cover larger populations than in many other areas. This suggests that patients in Wessex could find it harder to access NHS provided services than in some other areas.

“

Improve and maintain regular contact with patients post treatment, in rehab, etc. Communication is key. Compassionate care at all levels.¹¹

Comment from a patient”

10.4.5 **Where have we made a difference to date and areas of focus**

There are a number of areas of good practice across Wessex with regards to supporting patients living with and beyond cancer. These include:

- A strong focus on raising awareness and understanding of the importance of treatment summaries as a key part of the recovery package. Treatment summaries are included in all CCG commissioning intentions for 2015/2016
- Patient triggered follow up e.g. prostate cancer follow up systems
- Patient led support groups
- Health and wellbeing models
- Nutrition for survivorship e-learning package
- Practice cancer nurses
- Variety of exercise and physical activity programmes across Wessex targeting cancer patients, improving overall fitness, self-image, feeling of wellbeing and intention to sustain and continue exercise

Ambition 5

Within 5 years all Wessex patients with a new cancer diagnosis will be offered a holistic needs assessment, a primary care cancer review and a detailed treatment summary, as a consequence of the implementation of the recovery package

11. Drivers and enablers

The Wessex CCGs proposed that the SCN be tasked with describing a strategic vision for cancer services over the next five years. This proposal was ratified and approved by the Oversight and Planning Group of the Wessex Area Team in the summer of 2014. This decision was driven by acknowledgement of the significant national drivers for change, namely:

- Half of people with cancer survive at least 10 years¹
- There has been a 50% increase in suspected cancer referrals since 2009/10¹
- In 2010 there were 2 million people living with cancer nationally; this number is expected to rise to 4 million by 2030²
- The 62 day waiting time target achievement has dropped below 85% standard for first time and is at its lowest level since 2009/10¹
- £20bn is to be saved by NHS by 2014-15 with a projected additional £30bn funding gap between 2013/14 and 2020/21¹
- In 2012/13 UK cancer spend £5.7bn compared to £5.9bn in 2009-2010¹

Wessex is fortunate in many respects. Our region is well defined geographically, with the sharing of boundaries with many of the agencies involved in all aspects of health and social care. The Wessex Team hosts Specialised Commissioning for our area, in addition to having direct oversight of CCG commissioned pathways, and is therefore well placed to bring together all required agencies in the production of these recommendations.



12. Constraints, limitations and risks

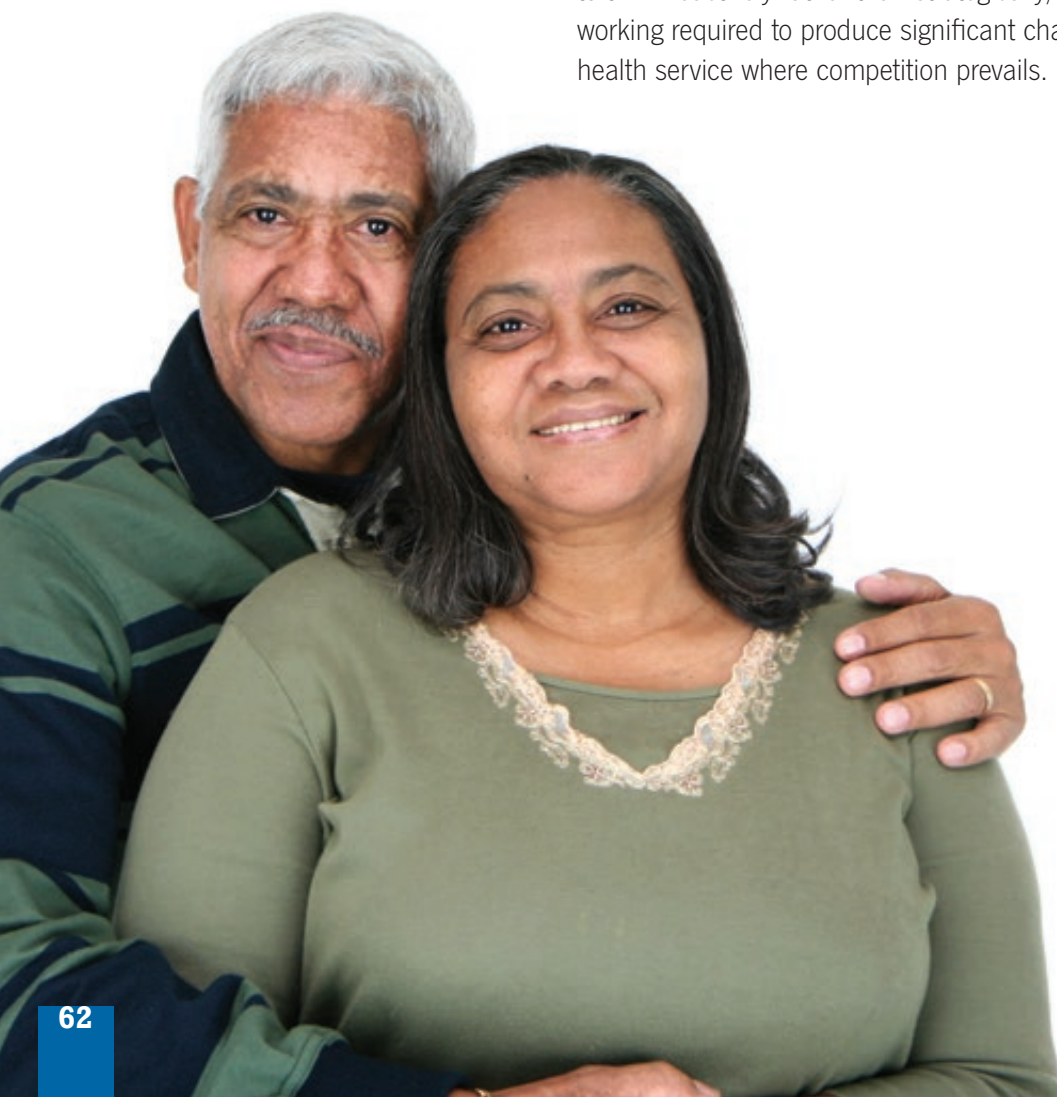
The recommendations contained in this document are of a generic nature and we have made no attempt to describe specific recommendations to commissioners about individual patient pathways and conditions. This is a function of our cancer Site Specific Groups, whose role is to advise providers and commissioners about current and future optimal disease specific patient care.

Commissioners are encouraged to follow the recommendations in this document; however, the SCN is not a statutory organisation and has no mandated power.

The forthcoming general election is likely to impact on the commissioning and provision of care for patients with cancer. However, the strategic vision we describe is, we believe, fully aligned to the current and likely future direction of the NHS.

We have made every effort to ensure that we have consulted widely and comprehensively in producing this guidance, but acknowledge that there will be those who feel their needs have not been met.

We believe that, aside from the economic challenges facing the UK, the most significant risk is that commissioners and providers of cancer care will continue to think reactively rather than strategically, and that the complex collaborative working required to produce significant change may remain a challenge in a health service where competition prevails.



13. Looking to the future and the role of research

The UK has the highest recruitment to clinical trials in the world, with one in every five people newly diagnosed with cancer being placed in a study. This is a huge increase over just a decade; before the National Cancer Research Network (NCRN) started in 2001, just 3.75% of patients would have been recruited to a trial in the UK, compared to 22.8% in 2011/12.⁶¹ Cancer Research UK suggests that survival rates have doubled since the 1970s thanks to research.⁶²

According to the US National Cancer Institute,⁶³ the benefits to a patient of participating in a clinical trial include the following:

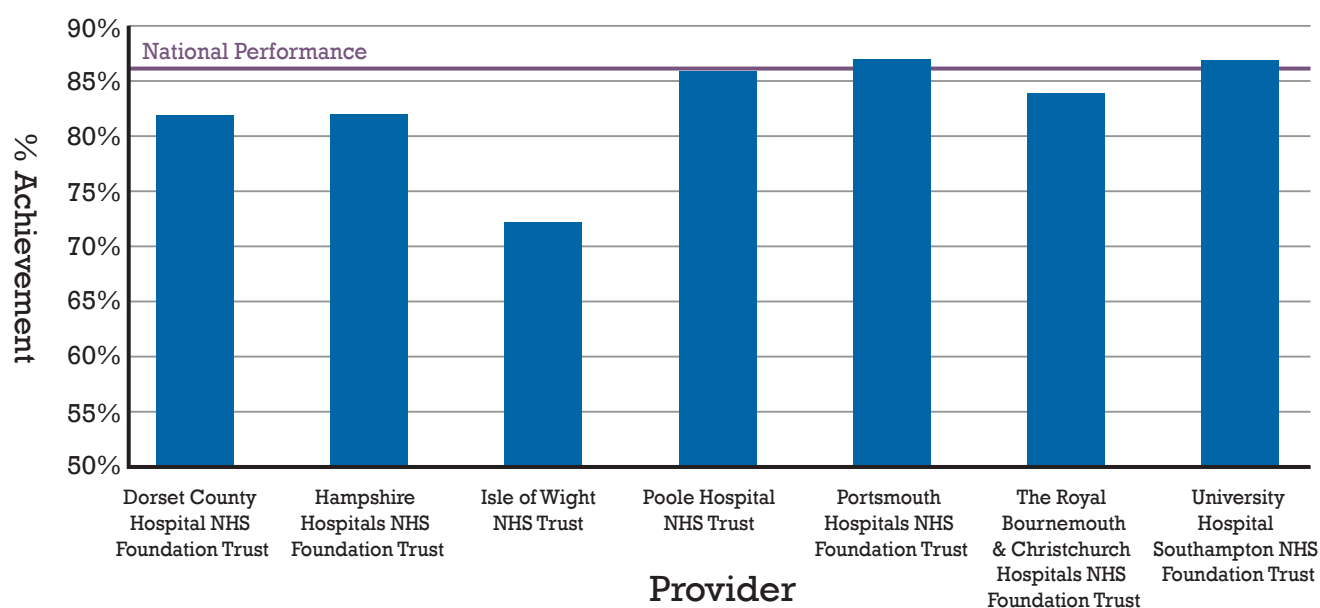
- Trial participants have access to promising new interventions that are generally not available outside of a clinical trial
- The results of the trial may help other people who need cancer treatment in the future

The Wessex Cancer SCN is partnered with the Wessex Clinical Research Network (CRN). Wessex cancer research networks have a successful track record of offering a broad portfolio of clinical trials to patients and delivering strong recruitment with patient participation increasing four-fold since 2002. The vision of the CRN for the next five years is to sustain this activity and ensure every patient in Wessex has the opportunity to take part in a clinical trial. Describing how this will be achieved, the Wessex CRN state:

“We will continue to support a broad portfolio of trials appropriate to our local population. We will monitor the national portfolio to ensure its breadth is reflected locally. We will support and encourage local clinicians to develop and run their own studies.”

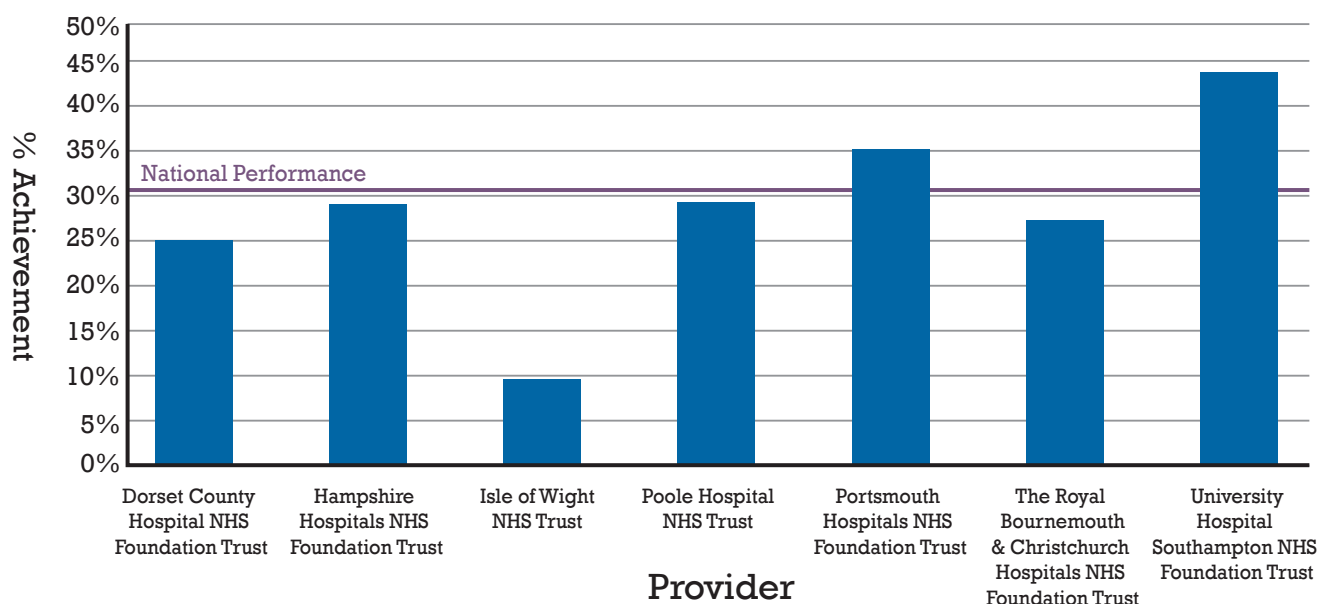
Findings of the National Cancer Patient Survey 2014 (Trust Level)⁵¹ indicate that access to information about clinical trials and the proportion of patients who enter clinical trials is highly variable:

% of patients across Wessex who had seen information (such as leaflets, posters, information screens etc.) about cancer research in their hospital? - Data taken from the 2014 National Cancer Patient Survey

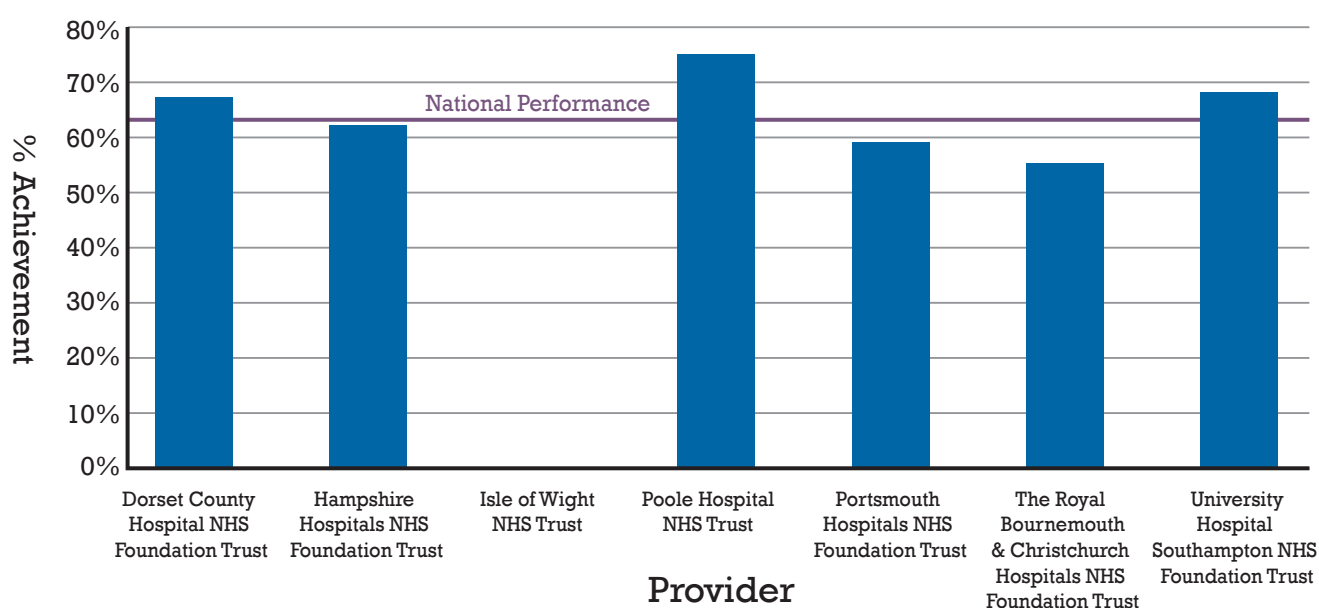


As shown below, some of our Acute Provider Trusts are above national average for discussing clinical trials with patients, although this remains variable across the area.

% of patients across Wessex who since their diagnosis, had someone discuss with them whether they would like to take part in cancer research? - Data taken from the 2014 National Cancer Patient Survey



**% of patients across Wessex where a discussion about taking part in cancer research was had, then went on to take part in cancer research?
- Data taken from the 2014 National Cancer Patient Survey**



It is clear from the patients' perspective that access to clinical trials is inequitable at present, although we will need to investigate these findings in more detail, as, for example, currently many IOW patients will receive their treatment at UHS or PHT, which may be affecting the results shown.

The results of our stakeholder engagement have confirmed the view that we should consider research as a priority:



More opportunity to access trials across Wessex.¹¹

Greater emphasis needs to be on research and development. Work closely with NHRI, NCRI, CRUK, etc and the Universities. Need to move forward to next generation of treatments and drugs and trials.¹¹

Comments from patients



The Wessex CRN outline that this is being tackled as below:

- Implementing strategies to ensure all patients are considered for participation in clinical trials. We will raise awareness of the local portfolio through the network tumour groups and at regional multidisciplinary team meetings (MDTs) to encourage referral of patients across the network. In collaboration with the national cancer research network team we will publicise trials involving rare tumours which are open at a few sites nationally so that where possible local patients can be referred.
- Identifying fourteen cancer sub specialty clinical research leads for Wessex who will provide a link between the national cancer research network team and clinical studies groups and local tumour groups and MDTs. They will champion research within the sub specialty; raising awareness of and promoting the portfolio locally (contact details available from Wessex CRN).
- Developing and supporting our workforce. There is a large team of highly experienced cancer research nurses and administrators across Wessex and we will ensure they are appropriately trained to support trial patients as we move into an era of highly complex personalised cancer treatments.

Ambition 6

All cancer patients who are eligible will be offered recruitment into a clinical trial, aiming for an aggregate at the national level.



14. Implementation

14.1 Leadership and membership

This strategic vision sets out the current status of cancer services in Wessex and outlines local priorities for the next five years. We will work closely with our partners (commissioners, providers, site specific groups, patients and the public, local authorities, the third sector, NHS England and the national cancer team) to develop a delivery plan which will describe specific ambitions in more detail and how we intend to reach these.

We will establish a Wessex Cancer Alliance (WCA) which will have oversight of the agreed delivery plan. The WCA will include membership representation from providers, CCG and Specialised Commissioners, Primary Care, Public Health, Health Education Wessex and the Wessex Clinical Research Network. The group will be chaired at executive level and be responsible to the Wessex NHS England South (Wessex) Team, to provide appropriate governance and ensure ambitions are realised accordingly to agreed timescales.

14.2 Measures for improvement

Identification and analysis of data and information to support implementation and measure improvement in cancer services will be a critical role of the WCA. Which sources of information to be utilised and baseline positions will be determined as the first task of the group, within six weeks of the publication of this document.

Measures will be published on the Cancer SCN website and quarterly progress reports and achievements, risks and issues will also be publicly shared.

14.3 Commissioning plans

The success of the Strategic Vision for Cancer Services, its delivery and ultimately the benefits to local public and patients will only be realised through collaboration with commissioners. Key recommendations and ambitions must be included in the commissioning plans of all 9 partner CCGs from 16/17 forward.




15. References

1. **Cancer Research UK, Health Services Management Centre at the University of Birmingham and ICF GHK Consulting** (2014). Measuring up? The health of NHS cancer services. London : CRUK.
2. **Maddams, J, Utley, M and Meller, H** (2012). Projections of cancer prevalence in the United Kingdom 2010-2040. *British Journal of Cancer*, 107: 1195-1202
3. **World Health Organisation** (2014). Cancer Prevention. [Online]. [Cited: 5 December 2014.] www.who.int/cancer/prevention/en/
4. **Cancer Research UK** (2014). Tobacco Statistics. [Online]. [Cited: 5 December 2014.] www.cancerresearchuk.org/cancer-info/cancerstats/causes/tobacco-statistics/
5. **World Cancer Research Fund** (2014). Cancer Preventability Statistics. [Online]. [Cited: 5 December 2014.] www.wcrf-uk.org/uk/preventing-cancer/cancer-preventability-statistics
6. **McGinty E, Zhang Y, Guallar E, Ford D., Steinwachs D, Dixon L, Keating N, Daumit G** (2012). Cancer Incidence in a Sample of Maryland Residents with Serious Mental Illness. *Psychiatric Services*, 63(7): 714-717.
7. **International Agency for Research on Cancer, World Health Organisation** (2014). European Code Against Cancer. IARC. [Online]. [Cited: 23 January 2014.] <http://cancer-code-europe.iarc.fr/index.php/en/>
8. **NHS England** (2014). Five Year Forward View. London : NHS.
9. **Department of Health** (2010). NHS Outcomes Framework 2011/12. London : DH.
10. **Department of Health** (2011). Improving Outcomes, A Strategy for Cancer. London : DH.
11. **Wessex Cancer SCN** (2014). Cancer Vision Survey - Comments. [Online]. [Cited: 13 March 2015]. www.wessexscn.nhs.uk/network-structures/cancer/resources/
12. **Cracknell, R** (2010). The ageing population. [Online]. [Cited: 5 December 2014.] www.parliament.uk/business/publications/research/key-issues-for-the-new-parliament/value-for-money-in-public-services/the-ageing-population/
13. **Barnett, K, Mercer, S, Norbury M, Watt G, Wyke S, Guthrie B** (2012). Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *The Lancet*. 380: 37-43.
14. **Office for National Statistics** (2013) Annual Mid-Year Population Estimates for the UK, ONS.
15. **Small Area Health Statistics Unit** (2010). The Environment and Health Atlas for England and Wales. [Online]. [Cited: 13 March 2015.] www.envhealthatlas.co.uk/eha/Breast/
16. **Macmillan Cancer Support** (2014). The Rich Picture on People with Cancer from BME Groups. Macmillan Cancer Support
17. **National Cancer Intelligence Unit** (2009). Travel times and distances to Radiotherapy. NCIN.
18. **National Radiotherapy Advisory Group** (2007). Radiotherapy: developing a world class service for England. London : NRAG.

- 
- 19. Public Health England** (2014), Public Health Outcomes Framework. [Online]. [Cited: 15 December 2014.] www.phoutcomes.info/public-health-outcomes-framework#gid/100044/pat/43/ati/102/page/0/par/x25004AD/are/E06000028
 - 20. American Cancer Society** (2011). Global Cancer Facts and Figures 2nd Edition. Atlanta: American Cancer Society.
 - 21. Oxford Cancer Intelligence Unit** (2007). Cancer Inequalities in South Central Strategic Health Authority Factsheet. [Online]. [Cited 5 March 2015.] www.sepho.org.uk/viewResource.aspx?id=11214
 - 22. World Cancer Research Fund** (2014). Lifestyle Statistics. [Online]. [Cited: 5 December 2014.] www.wcrf-uk.org/uk/preventing-cancer/lifestyle-statistics/
 - 23. National Cancer Intelligence Unit** (2012). Mortality, incidence and gender – malignant melanoma, NCIN.
 - 24. Macmillan Cancer Support** (2012). Cancer Genetics – How cancer sometimes runs in families.
 - 25. Manchanda R, Legood R, Burnell M, McGuire A, Raikou M, Loggenberg K, Wardle J, Sanderson S, Gessler S, Side L, Balogun N, Desai R, Kumar A, Dorkins H, Wallis Y, Chapman C, Taylor R, Jacobs C, Tomlinson I, Beller U, Meon U, Jacobs I** (2015). Cost-effectiveness of Population Screening for BRCA Mutations in Ashkenazi Jewish Women Compared With Family History–Based Testing. *Journal of the National Cancer Institute*, 107(1): 1-14.
 - 26. Cuzick J, Thorat M, Bosetti C, Brown P, Burn J, Cook N, Ford L, Jacobs E, Jankowski J, La Vecchia C, Law M, Meyskens F, Rothwell P, Senn H, Umar A** (2014). Estimates of benefits and harms of prophylactic use of aspirin in the general population. *Annals of Oncology*, 26(1): 47-57.
 - 27. National Institute for Health and Care Excellence** (2014). Aspirin; primary prevention of cancer and cardiovascular disease. London : NICE.
 - 28. Department of Health** (2014). Improving Outcomes, a Strategy for Cancer, 4th Annual Report. London : DH.
 - 29. Health and Social Care Information Centre** (2013). Cervical Screening Programme, England, 2012-13. HSCIC.
 - 30. Centre for Cancer Prevention** (2013): Breast Screening Results from the NHS Bowel Screening Programme 2012-13.
 - 31. NHS England Wessex Public Health Team** (2014). CCG analysis based on Open Exeter data.
 - 32. Wessex Cancer Strategic Clinical Network** (2014). www.wessexscn.nhs.uk/network-structures/cancer/achievements
 - 33. Holmes M, Chen W, Feskanich D, Kroenke C, Colditz G** (2005). Physical Activity and Survival after Breast Cancer Diagnosis. *Journal of the American Medical Association*, 293(20): 2479-2486.
 - 34. Meyerhardt J, Giovannucci E, Holmes M, Chan A, Chan J, Colditz G, Fuchs C** (2006). Physical Activity and Survival After Colorectal Cancer Diagnosis. *Journal of Clinical Oncology*, 24(22): 3527-3534.

- 35. Kenfield S, Stampfer M, Giovannucci E, Chan J** (2011). Physical activity and survival after prostate cancer diagnosis in the health professionals follow-up study. *Journal of Clinical Oncology*, 29(6): 726–732.
- 36. Mutrie N, Campbell A, Whyte F, McConnachie, Emslie C, Lee L, Kearney N, Walker A, Ritchie D** (2007). Benefits of supervised group exercise programme for women being treated for early stage breast cancer: pragmatic randomised controlled trial. *British Medical Journal*, doi:10.1136/bmj.39094.648553.AE
- 37. Public Health England** (2014). Cancer survival in England by stage. PHE publications gateway number: 2014292
- 38.** Data taken from the GP Practice Profiles for Cancer. Rates calculated by Trent Cancer Registry based on Cancer Waiting Times data for England, held on the DH Cancer Waiting Times Database. The GP Practice Profiles bring together a range of outcomes and process information relevant to cancer in primary care. They provide readily available and comparative information for benchmarking and reviewing variations at a general practice level. GP Practice Profiles are currently available within the NHS. www.ncin.org.uk/cancer_information_tools/gp_profiles.aspx
- 39. NHS England** (2015). South Region Cancer Waiting Time Standards Internal Report.
- 40. National Institute for Health and Care Excellence** (2014). Draft Guidance: Suspected cancer: recognition and management www.nice.org.uk/Guidance/InDevelopment/GID-CGWAVE0618
- 41. Elliss-Brookes L, McPhail S, Ives A, Greenslade M, Shelton J, Hiom S, Richards M** (2012). Routes to Diagnosis for cancer - Determining the patient journey using multiple routine datasets. *British Journal of Cancer*, 107: 1220–1226.
- 42. National Cancer Intelligence Unit** (2014). Routes to Diagnosis: Cancer of Unknown Primary. NCIN Data Briefing, NCIN.
- 43. Cancer Research UK** (2014). Saving lives, averting costs. London : CRUK.
- 44. Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales** (1995). A policy framework for commissioning cancer services. Calman Hine report. http://webarchive.nationalarchives.gov.uk/20080814090336/dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4071083
- 45. The All Party Parliamentary Group on Cancer** (2009). Inquiry into cancer inequalities. London : APPG.
- 46. NHS England and Cancer Research UK** (2014). A Vision for Radiotherapy, 2014-2024. <http://scienceblog.cancerresearchuk.org/2014/03/03/radiotherapy-our-vision-for-the-next-ten-years/>
- 47. Health Education Wessex** (2014). Education and Training Plan 2015/16. Commissions and Training Numbers.
- 48. National Institute for Health and Care Excellence** (2014). Children and young people with cancer-Quality Standard. London: NICE.
- 49. NHS England** (2013). Improving Outcomes: A Strategy for Cancer - Third Annual Report. London: Department of Health.
- 50. NHS Improving Quality** (2013). Enhanced recovery care pathway. London : NHS IQ/NHS England.

- 
- 51. Quality Health** (2014). National Cancer Patient Experience Survey. [Online]. [Cited: 15 December 2014.] www.quality-health.co.uk/resources/surveys/national-cancer-experience-survey/2014-national-cancer-patient-experience-survey
 - 52. The Royal College of Surgeons of England** (2014). From innovation to adoption. London : RCS Publishing.
 - 53. Royal College of General Practitioners, the Society and College of Radiographers, The Royal College of Radiologists** (2013). Quality Imaging Services for Primary Care: A Good Practice Guide. London: The Royal College of Radiologists
 - 54. Macmillan Cancer Support** (2013). Throwing the light on cancer and its consequences. London: Macmillan Cancer Support.
 - 55. Macmillan Cancer Support** (2014). A Competence Framework for Nurses: Caring for Patients Living With and Beyond Cancer. London : Macmillan Cancer Support.
 - 56. World Cancer Research Fund / American Institute for Cancer Research** (2009). Food, nutrition, physical activity and the prevention of cancer: A global perspective. Washington D.C. : AICR.
 - 57. Macmillan Cancer Support** (2013). Move More: Physical activity the underrated ‘wonder drug’. London: Macmillan Cancer Support.
 - 58. Wessex Strategic Clinical Networks** (2014). Rehabilitation, Reablement and Recovery Quality Guidance Document. Southampton : Wessex Strategic Clinical Networks.
 - 59. National Cancer Intelligence Network** (2014). Cancer Care in Wessex SCN.
 - 60. National Cancer Survivorship Initiative** (2014). Stratified Pathways of Care. [Online]. [Cited: 24 November 2014.] www.ncsi.org.uk/what-we-are-doing/risk-stratified-pathways-of-care
 - 61. The Royal Society of Edinburgh** (2012). Conducting Clinical Cancer Research in the NHS Benefits Everyone? Edinburgh: The Royal Society of Edinburgh.
 - 62. Cancer Research UK** (2014). Cancer research benefiting patients and the economy. [Online]. [Cited: 15 December 2014.] <http://scienceblog.cancerresearchuk.org/2014/06/16/cancer-research-benefiting-patients-and-the-economy/>
 - 63. National Cancer Institute** (2013). Cancer Clinical Trials. [Online]. [Cited: 15 December 2014.] www.cancer.gov/cancertopics/factsheet/clinicaltrials/clinical-trials



**Wessex
Strategic Clinical Networks**

©Copyright reserved. Wessex Strategic Clinical Networks, May 2015.

CS40648 Designed by NHS Creative