National Cancer Action Team

Part of the National Cancer Programme

The new commissioning framework, key messages and service specifications

NCIN Colorectal SSCRG
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Overall Commissioning Structure

From April 2013 – New commissioning system begins.

1. NHS Commissioning Board

"The purpose of the Board will be to use the £80bn commissioning budget to secure the best possible outcomes for patients."

- Supporting local clinical improvement
- Transforming the management of long-term conditions
- Providing more services outside hospital settings
- Providing a more integrated system of urgent and emergency care to reduce the rate of growth in hospital admissions

- Takes on full responsibilities and will hold CCGs to account and commission certain services
- National plus regional offices(4) and local offices (50)

Overall Commissioning Structure (cont)

2. Clinical Commissioning Groups (CCGs) – currently 220 in shadow form. Likely to change as they go through authorisation process.

3. Commissioning Support Services (CSSs) – currently 25 regional CSSs in total initially hosted by NHSCB. Must enable CCGs to harness new techniques and ways of working in order to allow them to deliver best value, timely and evidence based commissioning decisions. Being reviewed by NHSCB.

4. Clinical Networks

- part of new structure hosted by NHS CB – in15 geographical patches
- a number of strategic networks in each patch - one of which is cancer
- likely to see a reduction in management support with all networks
- will be responsive to commissioning aims and finance plans but also able to highlight where improvement is needed

Overall Commissioning Structure (cont)

5. Health and Wellbeing Boards

- designed to join up services from the NHS and social care and promote greater integration
- a committee of the Local Authority
- assess needs of local population through a Joint Strategic Needs Assessment (JSNA)
- to produce a local health and wellbeing strategy as the overarching framework within which commissioning plans are developed for health services, social care, public health and other services which the board agrees are relevant

NHS Outcomes framework 2012/13

1 Preventing people from dying prematurely

Overarching indicators

1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
1b Life expectancy at 75 i males ii females

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease*
1.2 Under 75 mortality rate from respiratory disease*
1.3 Under 75 mortality rate from liver disease*
Cancer
1.4 i One-and ii five-year survival from colorectal cancer
iii One-and iv five-year survival from breast cancer
v One-and vi five-year survival from lung cancer
vii under 75 mortality rate from cancer*

Reducing premature death in people with serious mental illness
1.5 *Excess under 75 mortality rate in adults with serious mental illness**

Reducing deaths in babies and young children
1.6.i Infant mortality* ii Neonatal mortality and stillbirths

Reducing premature death in people with learning disabilities
1.7 *An indicator needs to be developed*

2 Enhancing quality of life for people with long-term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions**

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition**

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions*

Reducing time spent in hospital by people with long-term conditions
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers**

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness **

Enhancing quality of life for people with dementia
2.6 *An indicator needs to be developed*

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital

Improvement areas

Improving outcomes from planned procedures
3.1 **Patient Reported Outcomes Measures** (PROMs) for elective procedures
i Hip replacement ii Knee replacement iii Groin hernia
iv Varicose veins

Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
3.3 *An indicator needs to be developed.*

Improving recovery from stroke
3.4 *An indicator to be derived based on the proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months*

Improving recovery from fragility fractures
3.5 The proportion of patients recovering to their previous levels of mobility / walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
3.6 Proportion of older people (65 and over) who were i still at home 91 days after discharge into rehabilitation*** ii offered rehabilitation following discharge from acute or community hospital ***

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
i GP services ii GP Out of Hours services iii NHS Dental Services
4b Patient experience of hospital care

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii NHS dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 *An indicator to be derived from the survey of bereaved carers*

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
4.8 *An indicator to be derived from a Children's Patient Experience Questionnaire*

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators

5a Patient safety incidents reported
5b safety incidents involving severe harm or death

Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare associated infection (HCAI) i MRSA ii C. difficile
5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

One framework
defining how the NHS will be accountable for outcomes
Five domains
articulating the responsibilities of the NHS
Twelve overarching indicators
covering the broad aims of each domain
Twenty-seven improvement areas
looking in more detail at key areas within each domain
Sixty indicators in total
measuring overarching and improvement area outcomes

The NHS Outcomes Framework 2012/13 at a glance

**Shared responsibility with the public health system and Public Health England and local authorities - subject to final publication of the Public Health Outcomes Framework.*

*** A complementary indicator is included in the Adult Social Care Outcomes Framework*

****Indicator replicated in the Adult Social Care Outcomes Framework*

Indicators in italics are placeholders, pending development or identification of a suitable indicator.

NCAT/NCIN cancer commissioning work

- Improving Outcomes: A strategy for cancer – NCAT/NCIN to develop a commissioning support pack

- Already have the Cancer Commissioning Toolkit and Cancer Commissioning Guidance

- Agreed to develop a commissioning pack
  - Key Messages for Cancer Commissioners
  - User Involvement in Cancer Commissioning
  - Service Specifications
  - Service Profiles

On the toolkit www.cancertoolkit.co.uk

- Also working to support development of JSNA guidance

Key Messages for commissioners

- Cancer patients are dying unnecessarily in all parts of the country (not just deprived areas).10,000 deaths could be avoided each year in England if survival matched the best in Europe. The government has set a goal to “save 5,000 lives p.a. Each year by 2014/15”
- On average a PCT or clinical commissioning group serving a population of 200,000 would save 40 lives p.a. If our survival rates matched those in Australia, Sweden or Canada
- The NHS spends around £6bn on cancer each year. The largest component of expenditure relates to inpatient care (exclusive of surgery and exclusive of chemotherapy costs)
- Investment in cancer services is currently inefficient –we should redirect resources from inpatient care to earlier diagnosis

Key recommendations for investment

- Invest in early diagnosis, especially:
  - Public awareness campaigns
  - Ensure access to existing screening programmes for all who can benefit (e.g. Faecal occult blood testing at ages 60-75 years)
  - Improved access to lower gastrointestinal endoscopy (e.g. Flexible sigmoidoscopy and colonoscopy) for patients with bowel symptoms
  - Prepare for flexible sigmoidoscopy screening. This has been shown to prevent cancer and to be cost saving
  - Improved access to chest x-ray (lung cancer) and ultrasound (especially pelvic ultrasound for ovarian cancer)
  - Important also that providers record staging and report this to their cancer registry

Key recommendations for disinvestment

- Reduce emergency admissions by providing better proactive support (e.g. for patients on chemotherapy) and ambulatory services (e.g. for symptom control)
- Increase day case or single overnight stay surgery (e.g. For breast cancer)
- Reduce lengths of stay through introduction of enhanced recovery programmes (e.g. For colorectal, urological and gynaecological cancer surgery)
- Reduce follow up through promotion of supported self management following primary treatment

Routes to Diagnosis

NCIN national cancer intelligence network
Using information to improve quality & choice

All Persons	Screen detected	Two Week Wait	GP referral	Other outpatient	Inpatient elective	Emergency presentation	Death Certificate Only	Unknown	Total	Number of patients
Acute leukaemia		**3%** *3% 4%*	**17%** *16% 19%*	**14%** *12% 15%*	**4%** *3% 4%*	**57%** *56% 59%*	**0%** *0% 1%*	**4%** *4% 5%*	**100%**	**2,551**
Bladder		**32%** *31% 33%*	**28%** *27% 29%*	**15%** *14% 16%*	**2%** *2% 3%*	**18%** *18% 19%*	**0%** *0% 1%*	**4%** *4% 5%*	**100%**	**7,665**
Brain & CNS		**1%** *1% 2%*	**17%** *16% 18%*	**14%** *13% 15%*	**4%** *4% 5%*	**58%** *56% 59%*	**0%** *0% 1%*	**6%** *5% 6%*	**100%**	**4,147**
Breast	**21%** *20% 21%*	**42%** *41% 42%*	**12%** *12% 12%*	**9%** *9% 9%*	**0%** *0% 0%*	**4%** *4% 5%*	**0%** *0% 0%*	**12%** *12% 12%*	**100%**	**34,232**
Cervix	**14%** *13% 16%*	**16%** *15% 18%*	**25%** *24% 27%*	**16%** *15% 18%*	**2%** *1% 3%*	**12%** *11% 14%*	**0%** *0% 1%*	**13%** *12% 15%*	**100%**	**2,085**
Chronic leukaemia		**10%** *9% 11%*	**30%** *28% 32%*	**12%** *11% 13%*	**2%** *1% 2%*	**30%** *28% 32%*	**1%** *1% 1%*	**16%** *15% 17%*	**100%**	**2,869**
Colorectal		**26%** *25% 26%*	**24%** *23% 24%*	**15%** *15% 16%*	**4%** *4% 4%*	**25%** *25% 26%*	**1%** *0% 1%*	**6%** *6% 6%*	**100%**	**27,903**

RtD – 1 yr survival

NCIN national cancer intelligence network
Using information to improve quality & choice

All Persons	All routes	Screen detected	Two Week Wait	GP referral	Other outpatient	Inpatient elective	Emergency presentation	Unknown
Acute leukaemia	40%		40%	37%	43%	***62%***	38%	38%
	38% 42%		*29% 51%*	*32% 42%*	*38% 48%*	*50% 71%*	*35% 41%*	*29% 47%*
Bladder	72%		***82%***	***81%***	75%	***86%***	***35%***	69%
	71% 73%		*80% 83%*	*79% 83%*	*72% 78%*	*79% 91%*	*33% 38%*	*63% 75%*
Brain & CNS	44%		51%	***60%***	***66%***	***58%***	***32%***	51%
	42% 46%		*37% 64%*	*57% 64%*	*62% 70%*	*50% 65%*	*31% 34%*	*44% 58%*
Breast	97%	***100%***	***98%***	96%	97%	91%	***53%***	97%
	96% 97%	*99% 100%*	*98% 99%*	*95% 97%*	*96% 97%*	*77% 97%*	*50% 55%*	*96% 97%*
Cervix	86%	***97%***	81%	***91%***	91%	85%	***49%***	***94%***
	84% 87%	*95% 99%*	*76% 85%*	*88% 94%*	*87% 93%*	*68% 93%*	*43% 55%*	*89% 96%*
Chronic leukaemia	78%		***95%***	***86%***	83%	87%	***54%***	***94%***
	77% 80%		*90% 98%*	*83% 88%*	*78% 87%*	*73% 94%*	*51% 58%*	*90% 96%*
Colorectal	73%		***82%***	***80%***	***83%***	***86%***	***48%***	70%
	72% 73%		*81% 83%*	*79% 81%*	*82% 84%*	*84% 89%*	*46% 49%*	*67% 72%*

Direct commissioning by NHS CB

The NHS CB will commission around £20bn worth of services directly, as set out in the list below.

- National and regional specialised services
- Primary care at general practice level
- Dentistry;
- Community pharmacy;
- Primary ophthalmic services;
- High-security psychiatric services;
- Healthcare for the armed forces and their families;
- Immunisation programmes;
- National screening programmes;
- HIV treatment;
- Children's public health services from pregnancy to 5yrs, including health visiting;
- Public health services for those in prison or custody;
- Contraception (as part of GP contract).

Specialist Cancer Commissioning

- The 10 Specialised Commissioning Groups, acting on behalf of their member PCTs, are currently responsible for the commissioning arrangements for specialised services.
- Defined in the Specialised Services National Definitions Set
  - Those services, treatments and interventions which either require service planning for populations of over one million and up to five million as specified in the relevant NICE guidance or are provided in fewer than 50 hospitals in England
  - E.g. Anal cancers and Liver resection

- Also there are Nationally Commissioned Services

  e.g. Pseudomyxoma peritonei surgery service

- Although chemotherapy and radiotherapy services not currently included in the definition of specialist cancer services likely they will be added

Service Specifications

- We are producing these for specialist cancer services and also for common cancers.

- Breast and Colorectal Specifications are available. Will be updated as required.

- These specifications are not constrained by what we have national data on, but aim to describe “What a good service looks like” and hence what should be commissioned.
  - When final version of the NICE quality standard for colorectal cancer is published these will included in the service spec .

- Format - schedule taken from the standard NHS Acute Services so can form part of contract.

Service Specification – colorectal

- Document is aimed at all CCGs – so focuses on the colorectal services they will be commissioning. Bowel Screening and specialist areas of colorectal cancer treatment are described but will be commissioned by NHSCB.
- Cancer Network role – NSSG
- Colorectal MDT
- Patient Information and patient experience
- Prevention (contribution to)
- Endoscopy services
- Imaging
- Staging
- Surgery
- Enhanced recovery
- Availability of laparoscopic surgery

Service Specifications – colorectal(cont)

- Audit – local and national (NBOCAP)
- Pathology
- Cancer Waits
- Access to hepatobiliary MDT
- Access to teams specialising in management of early rectal cancers
- Emergency pathways
- Acute Oncology Service
- Chemotherapy treatments and Radiotherapy treatments (likely to be commissioned by NHSCB)
- Follow up
- Supportive & Palliative care
- End of Life care

Metrics in the service specification are taken from the service profile

NICE Quality Standards

- Markers of high quality, cost effective, evidenced based care.
- Standards of excellence – NOT minimum standards but aspirational
- Descriptive statements of the critical infrastructural and clinical requirements for high quality care as well as desirable/expected outcomes
- NHS Bill 2012 – Commissioners must have regard to the quality standards prepared by NICE.
- Will be incorporated into the service specification

Draft NICE Quality Standard for Colorectal Cancer

(Publication due Aug 2012)

1. People presenting with symptoms suggesting colorectal cancer are referred to the designated colorectal diagnostic service within 1 day of the decision to refer.
2. People with suspected colorectal cancer without major comorbidity are offered colonoscopy to confirm the diagnosis, or CT colonography only if colonoscopy is difficult or unsafe.
3. People with colorectal cancer are offered contrast-enhanced CT of the chest, abdomen and pelvis to determine the stage of the disease, and those with rectal cancer are additionally offered MRI to assess the risk of local recurrence.
4. People with rectal cancer are offered a preoperative treatment strategy appropriate to their risk of local disease recurrence.
5. People with acute left-sided large bowel obstruction confirmed by CT are offered a colonic stent, if clinically appropriate, inserted within 24 hours by anendoscopist or radiologist experienced in using colonic stents, in consultation with the colorectal surgeon.
6. People with locally excised, pathologically confirmed stage I colorectal cancer whose tumour had involved resection margins (less than 1 mm) are offered further treatment by the colorectal cancer multidisciplinary team.
7. People with stage I rectal cancer are offered advice and options for further treatment from an early rectal cancer multidisciplinary team.
8. People with resectable colorectal cancer are offered laparoscopic surgery as an alternative to open resection if suitable, performed by surgeons competent in this technique.
9. People with a CT scan suggesting liver metastatic colorectal cancer are referred to the hepatobiliary multidisciplinary team to decide whether further imaging is needed to confirm suitability for surgery or other interventions.
10. People with advanced and metastatic colorectal cancer whose disease progresses after first-line chemotherapy are offered second-line chemotherapy if they are able to tolerate it.
11. People free from disease after treatment for colorectal cancer are offered regular surveillance.
12. People treated for colorectal cancer and their families or carers are offered specific information on managing the effects of the treatment on bowel function.

Any Questions?