



National Cancer Action Team  
Part of the National Cancer Programme

# Commissioning in the New NHS

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## The ambition

**To commission cancer services  
that are the best in the world**

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## The context within which we are trying to realise that ambition

- The quality of commissioning of cancer services has historically been variable
- Implementation of what has been dubbed one of the most radical plans in the history of the health service
- Introduction of some key changes to those plans following the listening exercise

## Some weaknesses in commissioning and information (1)

- Aspects of cancer information have improved substantially since publication of the Strategy, but key gaps and limitations remain
- Few commissioners, however, make best use of the information available when commissioning cancer services and most do not know whether their commissioning is cost-effective
- While there have been measurable improvements in efficiency by treating more people as day cases, and reductions in length of stay, there is substantial scope to make further improvements by tackling variations and raising performance to the standard of the best

## Some weaknesses in commissioning and information (2)

- Although there have been improvements in some aspects of cancer information, commissioners' poor understanding of costs and outcomes mean that they do not know whether they are commissioning services which optimise outcomes for patients
- Incomplete and inconsistent data on how advanced patients' cancers are at diagnosis limits understanding of variations in outcomes
- The number of patients recorded as being treated with chemotherapy is increasing but there are quality issues with these chemotherapy data

## What have we said in Improving Outcomes: A Strategy for Cancer

- Information will be central to the drive for better outcomes
- Commissioners will need accurate, relevant, contextualised, timely and accessible information
- Commissioners will want information that is:
  - Informing
  - Engaging
  - Empowering

## Priorities for 2011/12 identified in the IOSC include:

- Collating and publishing high quality information about:
  - Incidence
  - Prevalence and survival
  - Different aspects of cancer and the outcomes they deliver
- Improving the quality of the data which underpins expenditure information on cancer services

## The new commissioning environment

- The Government will devolve power and responsibility for commissioning services to the healthcare professionals closest to patients: GPs and their practice teams working in consortia
- An independent and accountable NHS Commissioning Board will be established

## The Government's response to the listening exercise (1)

- Commissioning consortia will continue to be groups of GP practices, but will involve patients, carers and the public and a wide range of doctors, nurses and other health and care professionals
- In future they will be called "clinical commissioning groups"
- Every clinical commissioning group will have a governing body with decision-making powers. That body will include at least one registered nurse and one doctor who is a secondary care specialist
- The groups will not be authorised to take on any part of the commissioning budget until they are ready and willing to do so. Until they are ready the local arms of the NHS Commissioning Board will commission on their behalf

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## The Government's response to the listening exercise (2)

- Clinical networks will be retained and strengthened
- They will be give a stronger role in commissioning in support of the NHS Commissioning Board and local clinical commissioning groups
- "Clinical senates" of doctors, nurses and other professionals will be established with the role of:
  - Giving expert advice which clinical commissioning groups will be expected to follow
  - Authorisation of clinical commissioning groups
  - Advising on whether commissioning plans are clinically robust
  - Advising on major service changes
- Both clinical networks and clinical senates will be hosted by the NHS Commissioning Board

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## The approach we are taking

- Engagement with GP Consortia
- Identification and delivery of a set of key messages

## Developing key messages for commissioners

Questions:

- What are the key facts/issues about cancer that **we** would want commissioners to know?
- What do **they** feel is most important to know?
- How can we (NCIN/NCAT and cancer networks) best support them?

## What do we want commissioners to know?

1. Cancer patients are dying unnecessarily in all parts of the country (not just deprived areas). On average a consortium serving 200,000 population would save 40 lives p.a. if our survival rates matched those in Australia, Sweden or Canada
2. **Late diagnosis** is the major factor underlying the poor survival rates in this country
3. There are a number of myths about cancer that need to be dispelled

## Myths about cancer (1)

1. **Myth 1:** Cancer has had more than its fair share of the growth in NHS funding in recent years  
**Wrong:** Cancer accounts for 6% of NHS budget and this has remained static
2. **Myth 2:** Cancer is a secondary and tertiary issue. It has little to do with primary and community care  
**Wrong:** Primary care has major roles in early diagnosis, ongoing support and end of life care for cancer patients

## Myths about cancer (2)

**3. Myth 3:** All cancer interventions are highly expensive

**Wrong:** Many interventions with the greatest impact are highly cost effective (e.g. smoking cessation, screening, early diagnosis, surgery, radiotherapy and some curative chemotherapy). It is true that some chemotherapy given at the end of life is much less cost-effective

**4. Myth 4:** Too much attention has been given to cancer. We should turn our efforts to other conditions

**Wrong:** Survival rates following a diagnosis of cancer remain poor in England. Earlier diagnosis of cancer could save thousands of lives p.a.

## How can we best support commissioners?

We can tell them how they can:

- Save lives
- Improve patients' quality of life and experience of care
- Get optimal value for money

We can supply benchmarking information, together with expert interpretation, advice and support for implementation at different levels, including network, consortia, GP practice and Trust/service levels



## Saving Lives

This can be achieved by:

- Public awareness campaigns promoting earlier presentation (e.g. bowel cancer)
- Supporting GPs to investigate/refer appropriately
- Providing GPs with better access to diagnostics (e.g. CXR, U/S, endoscopy, brain MRI)

This is not simply a matter of patients living a few extra months. It can often be the difference between early death and long term survival/cure

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## Improving Patient Experience

- Preventing unnecessary hospital admissions
- Reducing lengths of stay
- Improving access to CNSs
- Supporting initiatives such as patient information prescriptions and advanced communications training

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## Achieving Optimal Value for Money

- Invest in early diagnosis
- Reduce emergency admissions by providing better proactive support (e.g. for patients with chemotherapy) and ambulatory services (e.g. for symptom control)
- Increase day case surgery
- Reduce lengths of stay by introducing enhanced recovery programmes/overnight breast surgery model
- Reduce follow up promotion of supported self-management following primary treatment

## Benchmarking Information

e.g. Service profiles which will include:

- The range of services provided by each Trust
- Whether each team has core members from all the relevant disciplines
- Whether the team has a CNS
- How many patients by equality characteristic were diagnosed/treated in the previous year
- Compliance with waiting time standards
- Compliance with peer review measures
- Major resection rates
- Mortality rates within 30 days of treatment

## Development of service profiles

Metric	NHS Outcomes Framework Domain	Level data available	Data Source
<b>Demographics of MDT</b>			
Median age of patients referred/treated	Background Info	MDT	Ca. Reg
Ethnicity of patients referred/treated	Background Info	MDT	Ca. Reg
IMD Score	Background Info	MDT	Ca. Reg
Stage of cases referred/treated	Background Info	MDT	Ca. Reg
Co-morbidity of cases referred/treated	Background Info	MDT	Ca. Reg
<b>Specialist Team</b>			
Does the specialist team have full membership	5-Safety	MDT	NCPR
How well did it score on peer review?	5-Safety	MDT	NCPR
Were there any immediate risks?	5-Safety	MDT	NCPR
Were there any serious concerns?	5-Safety	MDT	NCPR
Availability of a named clinical nurse specialist	4-Patient Exp	MDT	CPES
Funded CNS posts	4-Patient Exp	MDT	NCAT Census - 2010
% colorectal cancer cases undergoing a major surgical resection	5-Safety	Trust	HES
% colorectal cancers radiologically staged with CT scanning	5-Safety	MDT	NCPR/NBOCAP

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## Cancer Service Profiles



Select trusts of interest by Network and/or Trust below

<input type="checkbox"/>	3 Counties	<input type="checkbox"/>	Gloucestershire Hospitals NHS Foundation Trust
		<input checked="" type="checkbox"/>	Hereford Hospitals NHS Trust
		<input type="checkbox"/>	Worcestershire Acute Hospitals NHS Trust
<input type="checkbox"/>	Anglia	<input type="checkbox"/>	Bedford Hospital NHS Trust
		<input type="checkbox"/>	Cambridge University Hospitals NHS Foundation Trust
		<input type="checkbox"/>	Hinchingbrooke Health Care NHS Trust
		<input checked="" type="checkbox"/>	Ipswich Hospital NHS Trust
		<input type="checkbox"/>	James Paget University Hospitals NHS Foundation Trust
		<input type="checkbox"/>	Norfolk and Norwich University Hospital NHS Trust
		<input type="checkbox"/>	Papworth Hospital NHS Foundation Trust
		<input type="checkbox"/>	Peterborough and Stamford Hospitals NHS Foundation Trust
		<input type="checkbox"/>	The Queen Elizabeth Hospital King's Lynn NHS Trust
		<input type="checkbox"/>	West Suffolk Hospitals NHS Trust
<input checked="" type="checkbox"/>	Arden	<input checked="" type="checkbox"/>	George Eliot Hospital NHS Trust
		<input checked="" type="checkbox"/>	South Warwickshire General Hospitals NHS Trust
		<input checked="" type="checkbox"/>	University Hospitals Coventry and Warwickshire NHS Trust

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## Cancer Service Profiles Indicators



### Anywhere Hospitals NHS Trust

Domain	Indicator	Value	England	
Demographics	Fraction of patients over 70	34%	40%	
	Fraction of patients with non White-British Ethnicity	14%	10%	
	Deprivation quintile	2	3	
	Fraction in stage 1 or 2	89%	60%	
	Fraction with Charlson comorbidity index >0	34%	50%	
Specialist team	Specialist team has full membership	yes	yes	
	Peer review score	0.87	0.9	
	Peer review: immediate risks?	no	no	
	Peer review: serious concerns	no	no	
	Proportion patients reporting CNS available	74%	90%	
	Number funded CNS posts	5.25	5	
	Proportion of newly diagnosed cases undergoing major resection	40%	60%	
Size/throughput	Proportion of newly diagnosed radiologically staged with CT scanning	49%	70%	
	Each surgeon manages 30+ cases per year	yes	yes	
	Urgent referrals per year	101	80	
	Cancers managed per year	288	200	
	Annual major operations	73	100	
Waiting Times	% of urgent referrals seen within 2 weeks	97%	95%	
	% of urgent referrals treated in 62 days	58%	95%	
	% patients treated in 31 days	91%	95%	
	% symptomatic breast referrals seen in 2 weeks	97%	95%	
	% of TWW referrals with cancer	11%	10%	
	% new cases that are TWW	20%	40%	

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## Conclusion

The primary focus of all NHS funded care should be the provision of high quality care and improved outcomes for patients.

Our ambition is to commission and deliver cancer services that match the best the world.

The challenge is a significant one but the prize is great!

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