EXECUTIVE SUMMARY

Quick Wins for Commissioning High Quality Cancer Services:

Recommended Actions from the Frontline

"I now realise our consortia needs to engage with the Cancer Networks as this is a good area to start getting our teeth into real clinical commissioning"

COMMISSIONED BY:

nhsalliance

NHS National Cancer Action Team

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medical management services

where medicine meets management

"Here is our pot of money. We need to decide what can we afford."

"I didn't even know cancer networks existed. CCGs need to understand their role. Networks need to prove their value and expertise."

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- North Central London & West Essex Cancer Network
- Anglia Cancer Network
- Peninsula Cancer Network
- Dorset Cancer Network
- 3 Counties Network
- Avon, Somerset & Wiltshire Cancer Network
- East Midlands Cancer Network
- Central South Coast Cancer Network
- Sussex Cancer Network
- Greater Manchester & Cheshire Cancer Network

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The views expressed in the report do not necessarily reflect the views of NCAT, the NHS Alliance, Amgen, Roche, BMS, Avon, Somerset & Wiltshire Cancer Network

Copies of full report available at: www.medman.co.uk

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Over the last decade, improvements in integrated working and increased specialisation in secondary care, together with improvements in treatments have contributed to improvements in survival rates for many cancers. Yet, survival rates and outcomes in The United Kingdom still lag behind European countries. This is mainly down to late diagnosis.

Much of the focus in cancer care has been on secondary and tertiary care with less attention being paid to the role of general practice in diagnosing and treating patients with cancer. However, primary care now needs to play a pivotal role in improving outcomes. Emerging challenges in primary care include:

- Facilitating early diagnosis
- Supporting people through treatment and into survivorship
- Supporting people, families and carers towards a good end of life experience.

Despite perceptions that cancer gets more than its fair share of the cake, NHS spending on cancer has remained stable for over a decade at 6% of the total NHS budget.

Cancer remains an emotive subject in British society. It is high on both politicians' and the public's agendas. That is unlikely to change. CCGs will find themselves being held to account by both for progress and improvement in cancer outcomes.

Across England there are approximately 250,000 new cases of cancer a year, predicted to rise to (apportion 300,000) by 2030. Assuming there are 250 CCGs serving a population of 200,000 they will see approximately 1,000 new cases per year. Cancer will account for about 12% of all their acute admissions.

If cancer survival rates match the European average through the commissioning strategies adopted by CCGs, it is anticipated that by 2014-2015 an additional 5,000[1] lives will be saved each year. In a population of 200,000, this equates to 20 lives saved.

Cancer specialists already have a pretty good picture of what needs to be done differently. For example, to achieve earlier diagnosis, we need to improve clinicians' and people's knowledge of signs and symptoms of concern worthy of further investigation through awareness campaigns and continuing professional development. We need to change peoples behaviour so that they report to their GP far earlier than many do at present, and we need to increase rapid access to tests such as flexible sigmoidoscopy for bowel cancer, chest x-ray for lung cancer, pelvic ultrasound for ovarian cancer. Where it is clinically appropriate, we also know there is the opportunity to deliver more cancer care in settings closer to patients' homes so that treatment interrupts peoples' lives less and frees up hospital capacity.

In the summer of 2011, the NHS Alliance and the National Cancer Action Team (NCAT) brought representatives from over 30 clinical commissioning groups and ten cancer networks together with patient representatives, PCT clusters, GPs with a special interest and secondary care providers in 5 focus groups to learn from each other and discuss and debate the opportunities and challenges around commissioning of cancer services.

The key message was that people see the current commissioning reforms as an opportunity to think and do things differently. Whilst cancer commissioning remains just one of a number of competing priorities for CCGs, by appointing a cancer lead now; sharing the commissioning task and building on CCGs' expertise in population based health improvement and cancer networks' wealth of expert knowledge of best practice, there is an opportunity to drive large scale improvement through integrated commissioning so that people with cancer are picked up early and experience high quality, person centred care throughout their journey.

Ref 1 : Improving Outcome: A Strategy for Cancer, DH – January 2011

Significant work has already been done to identify the right level and population base for commissioning in cancer. During the transition period it is important that we retain corporate memory and keep it accessible to CCGs so they can fast track their knowledge and maximise progress within limited resources.

By setting out the key challenges and capturing what we know already, this paper aims to provide a set of practical actions for all stakeholders involved in cancer commissioning and to suggest how they can deliver some quick wins. We hope it will provide food for thought and stimulate discussion and engagement between CCGs and cancer networks about the best way to ensure the effective commissioning of cancer services in the future.

From an analysis of the feedback from our five focus groups, we have identified three themes that hallmark the challenge of developing an integrated cancer commissioning model for the future. The rationale for their importance and the detail of what needs to be done to achieve change is summarised in brief below. Further detail can be found in the main report.

Getting the process right

A key challenge for CCGs is getting to grips with the right investments to make to improve cancer care. Cancer networks are a treasure trove of information and knowledge about best practice and how to improve outcomes. CCGs are on a steep learning curve and would welcome input to help identify priorities and how services are best configured. CCGs would like information on options for service improvement to be available in standardised business case formats that include economic analysis of different interventions so they can make decisions on an 'invest to save' basis; for example, a cost comparison of flexible sigmoidoscopy screening programmes versus the costs of a bowel re-section, associated chemotherapy and stoma care products when a cancer is discovered later.

Moving forward, CCGs will be in the driving seat. They are already considering whether they want to:

- Build new ways of doing commissioning in-house;
- Share commissioning for cancer care across CCGs; or
- Buy commissioning support from external sources.

CCGs covering larger population bases will be better placed to 'build' in house commissioning support. Yet, within cancer commissioning, the biggest win is likely to come from sharing. As cancer networks start to redefine their role, whilst remaining unambiguously legally responsible, CCGs might consider delegating authority to a trusted network partner to lead cancer commissioning. Alternatively, they might choose to delegate cancer commissioning to a local 'lead' CCG.There is a lot at stake for cancer networks. They need to start involving CCGs now. As networks tend to have a significant secondary care focus and have each operated in slightly different ways, participants felt it was hard to recommend what any future network model might look like. However, they were united in recognising that CCGs and networks needed to start that conversation quickly as part of transition and CCG development planning.

CCGs will have a legal duty to support and drive up quality in primary care. It is clear that primary care has a pivotal role to play in improving cancer outcomes. CCGs need to develop a compelling narrative to engage their member practices in the push to improve early diagnosis. Networks may be able to help with this.

Whilst responsibility for achieving the '5,000 lives target' is likely to belong to the NHS - as much of it will be down to increasing diagnostic capacity - NHS commissioners will have to work closely with Public Health England to achieve it.

Contracting is most likely to be shared and to be an outsourced function. However, clinical commissioners will need to input to the contracting process; and importantly get contract specification right to ensure focused performance management that delivers accountability and not what secondary care wants to provide; NICE Guidelines and the NHS Outcomes Framework.

Building on existing assets

Retaining corporate memory is key so that CCGs know what is going on now; what work has been done in the past and what improvement and service development work is planned for the future. Recognising this, the Department of Health has committed to fund cancer networks through NHSCB for the time being.

CCGs participating in our focus groups had a wide range of levels of understanding and knowledge of cancer networks. Some GPs actively involved in clinical commissioning did not even know they existed; and many did not know what they did.

Likewise, few of those active in cancer networks understand CCGs and the challenges they face. Whilst CCG leads saw cancer was important, it was just one of many competing priorities – and felt that it was critical that Cancer Networks understood clinical commissioning so that they could support CCGs in constructive, concise and accessible ways. There is a significant opportunity for cancer networks and CCGs to learn from each other and build on their existing assets. Working together, CCGs and networks have the right resources to reinvigorate commissioning and improve cancer outcomes.

Cancer networks are currently perceived as facilitators and enablers that spread good practice and encourage peer learning across the NHS. If networks respond to change; add value to CCGs and build a reputation for collaborative working, CCG leaders felt that some health economies might decide to delegate responsibility to networks for cancer commissioning and champion that role with NHSCB. Participants warned of the potential reputational risk to networks of being hosted by the NHSCB – and the danger of them being seen by CCGs as outposts with a role in performance management.

As an immediate priority, everyone agreed that cancer networks should consolidate their relationships with CCG leaders and that the focus of early discussions should be on quick financial wins and money saving ideas.

Innovation in service delivery

The current annual £6 billion spend on cancer care remains inefficient. Clinical commissioning needs to refocus investment and drive it into more overnight breast surgery, enhanced recovery programmes and preventing inappropriate emergency admissions and redirect investment towards earlier diagnosis and better support for primary care engagement in achieving earlier staging in diagnosis and treatment.

Whilst ‘seed corn investment’ might support innovation, ultimately CCGs need to deliver cash savings in cancer care to free up funding for early diagnosis. Everyone acknowledges that fundamental change is necessary. CCGs are going to carry the responsibility for tough and necessary decisions about service redesign. NHSCB needs to support them so they can follow through.

Redesign needs to be well managed. Best practice shows that engaging early with all stakeholders is key. Providers need to own the change and work collaboratively with the clinical commissioning team. All decisions need to be based on robust evidence and demonstrate how they will improve clinical care. Cancer networks can help support service redesign.

The frontline participants recommended below some early actions for stakeholders to consider. It must be noted these are recommendations from the focus group participants and do not necessarily reflect the views of NCAT, the NHS Alliance and other organisations involved in this project. The recommendations are summarised below:

Recommended actions for CCGs

- Recognise the National and political importance of cancer
- Appoint a named CCG cancer commissioning lead to liaise with CCG colleagues and network
- Link in early and join forces with cancer networks

- Involve local cancer support groups and the third sector operating in your CCG in commissioning
- Commission at the right level. It will vary for different cancers. Specialist commissioning will remain. Work with specialist commissioners for appropriate cancers
- 'Build', 'share' or 'buy' to maximise value for money and quality of cancer commissioning support. See cancer networks as assets and work with their expertise
- Establish current spend on cancer care
- Use existing data to its full potential; especially NCAT and NCIN GP practice and provider profiles
- Work with PCT clusters and providers to gather additional commissioning data and complete the picture of population need; identify current strengths and weaknesses in delivery and outcomes
- Work up business cases for disinvestment in secondary care of cancer through reduced length of stay post surgery and improved community based services
- Work up business cases for investment in improved diagnosis and screening in primary care
- Develop a compelling narrative and engage GPs and the wider primary care team in improvement and early diagnosis Target screening programmes at high risk groups working closely with Health & Wellbeing Boards
- Think integration and work with CCGs and cancer networks to commission end-to-end care pathways.

Recommended actions for providers

- Appoint a named cancer care lead to liaise with CCGs and work on reconfiguration plans
- Work collaboratively with CCGs to redesign cancer care
- Put in place a feedback and learning system to support GP referral. This process may also help CCGs to identify practices which are under-referring to secondary care
- Redesign hospital based cancer services; make them more productive. Specifically, examine the length of cancer inpatient stays and outpatient follow-up
- Focus on community based care; be prepared to shift services into primary care and increase capacity for screening for early diagnosis
- Gather feedback from people using services about what works well and what can be improved
- Innovate by working with people with experience of cancer and CCGs to create new thinking around service design and delivery

Recommended actions for networks

- Appoint a named network lead to link with CCGs
- Engage with CCG leaders as a priority. Communicate 'top tips' and 'early wins' for CCGs. Show the value you can add
- Proactively communicate current cancer strategy to all new commissioners and providers across the network
- Ensure co-ordination of messages across other clinical networks
- Build trust and demonstrate the value of networks as facilitators and 'honest brokers'. Networks' experience, knowledge and understanding makes networks strong candidates for outsourcing commissioning support
- Use patient stories as a learning and engagement tool; stories are a powerful tool for service improvement, sense-checking and redesign. They are also important hooks to engage and win clinicians' attention

- Add value to data and proactively provide information and intelligence that enables a one glance overview, including key data sets and local dashboards. Networks can also help CCGs to understand service and commissioning data and how best to configure commissioning for different cancers
- Support CCG leads to develop and deliver business cases. Develop guides on where to invest - and where to disinvest
- Showcase sustainable and lean commissioning support models by marketing network data, intelligence, experience and services to CCGs
- Stand in the shoes of CCGs to design resonant information and commissioning support offers. Remember CCGs have competing clinical commissioning priorities and are time poor. Be creative. Choose on line and summary formats
- Promote and align peer review improving clinical outcomes. Help providers to benchmark with peers and national standards

Recommended actions for National Cancer Action Team

- Build accurate benchmark costs for the whole cancer pathway; CCGs needed a very granular understanding of costs
- Continue development of performance dashboards so that CCGs have an accurate one glance overview of progress
- Create data sets to help CCG benchmark against their peers.
- Improve health economic appraisal and offer more 'ready-made' health economic appraisals on changes in care configuration. Develop an evidence-based list of 'early wins' where service changes can lead to savings
- Define appropriate population bases for commissioning for specific tumours in line with emerging evidence and changing technology
- Develop 'Desert Island Metrics'; the top 5 indicators that demonstrate quality of cancer care plus the 5 questions every patient should ask to identify the right provider for them. NCAT should also raise awareness amongst the public of the GP practice and forthcoming service profiles for cancer teams they are developing
- Produce a list of High Impact Changes in Cancer Commissioning outlining evidence-based early wins that would lead to savings. Ideally this would include examples where it has worked
- Produce ready-made appraisals on the costs of changing care provision
- Raise awareness of enhanced recovery and outline suggested criteria for referral to these services
- Present data for busy GPs; no more than 4 sides of A4, with links to online news and notes to back up the points made

Recommended actions for NHS Commissioning Board

- Create a supportive culture for reconfiguration; enable CCG leaders to follow through with plans and feel that responsible, proportionate risk-taking will be unequivocally supported
- Mandate minimum data sets as part of provider tariffs; make collection of minimum data sets mandatory as part of the tariff. If data is not provided, it should mean no payment

Recommended actions for pharmaceutical industry

- Build on experience, expertise and resources through transparent relationships that focus on the patient and address shared agendas
- Mirror best practice in partnership working like the Pharmaceutical Oncology Initiative Partnership, NCAT and NHS Improvement web based Chemotherapy Planning Online Resource (C-PORT)

- Extend joint working initiatives to early diagnosis, community based service delivery, necessary service redesign in hospital based care and supporting other efficiencies

In conclusion, when it comes to cancer commissioning, CCGs are definitely in good company. Whilst they face many competing priorities, making a few early decisions and most importantly, appointing a clinical commissioning lead will kick start action and set CCGs on the road to improving cancer outcomes. It's a small investment for potentially a very big win.

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“Networks can be the honest broker between CCGs and providers; to ensure the providers meet clinical guidelines and the objectives of the CCG.”

“Identifying easy savings will get you through the door.”

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