

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”

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**Quick Wins for Commissioning High Quality Cancer Services:
Recommendations from the Frontline**

“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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- Anglia Cancer Network
- Peninsula Cancer Network
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- 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

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EXECUTIVE SUMMARY

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 5,000¹ 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.

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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, as they will be overseeing screening.

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

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- 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.
- 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

Recommended actions for providers

- Appoint a named cancer care lead to liaise with CCGs and work on reconfiguration plans

- 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)

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- 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.



INTRODUCTION: THE CANCER COMMISSIONING CHALLENGE

Whilst improvements in outcomes have been made, the UK still lags behind its European counterparts.

Cancer remains a key priority; and the Government's response to the Future Forum Report emphasised this. The general public see cancer as an important issue and so improving cancer outcomes will remain politically sensitive.

Despite peoples' perception that cancer has received disproportionate increases in funding, cancer continues to receive a steady 6% of the NHS budget; and this has been the case for over a decade. Overall, The NHS now faces zero real term funding growth so CCGs need to deliver improvement within the same financial envelope.

The Government wants to save 5,000 lives a year by 2014-15 and improve UK cancer outcomes in line with European average. Primary care has a critical role in achieving this improvement. The main focus within cancer care today is on driving early diagnosis and moving towards more cost-effective treatment methods that are delivered in the most appropriate setting.

There is a strong business case for diagnostic tools like flexible sigmoidoscopy. They are cost-saving. Treating colorectal cancers at Dukes A stage rather than Dukes D Management - as seen in primary care led programmes in Southampton, Isle Of Wight and Portsmouth (SHIP) PCTs – proves the point.

Whilst many national targets have been abandoned, one of the few remaining is the two-week wait for suspected cancer diagnosis referral to a specialist. That is because it improves early diagnosis and thus outcomes. Emergency presentation with cancer is likely to remain a further proxy measure for quality in the future.

There is a widely held view people living with cancer in England also spend more time than their European counterparts in hospital. The Government wants to improve service quality by shifting cancer care into the community and reducing length of stay

in secondary care. For instance, much breast cancer surgery can be done as day case surgery or overnight; implementing enhanced recovery programmes reduces colorectal cancer bed days from 10-14 days down to just 4 without compromising quality². Reducing outpatient visits in breast and prostate cancer can also offer savings - as can improving care through empowering people to self manage their cancer - with the caveat that people need responsive, fast access to clinical support when they are experiencing a problem.

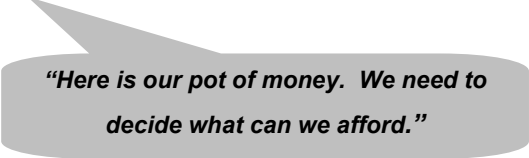
From 2013, the NHS Commissioning Board (NHSCB) will mandate CCGs to deliver improved outcomes for cancer care. Whilst the NHSCB will be responsible for some specialist commissioning in cancer, many of the improvements that will have the greatest impact on outcomes are in the gift of CCGs. Key will be achieving early diagnosis. Action to achieve early diagnosis means doing things differently in primary care.

This means effective commissioning of cancer services needs to be a key priority for CCGs.

THEME ONE: GETTING THE COMMISSIONING PROCESS RIGHT

The watchwords of current reform are: **information, choice, competition and clinical commissioning**. These will be the key drivers for quality and improved outcomes.

Commissioning the right things



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

A key challenge for GPs is getting to grips with the right investments 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 need help to decide priorities and how services are best delivered.

With the focus now on outcomes and quality improvement, better quality, more timely data is needed more than ever. Participants praised the work of cancer registries for example ECRIC that is used in Somerset and East Anglia, which are entering data on diagnosed cancer patients in close to real time.

The National Cancer Action Team (NCAT) and National Cancer Intelligence Network (NCIN) collect a lot of central benchmarking information. However, there is poor data on other aspects vital to cancer care. For instance, chemotherapy data is held locally in acute trusts; likewise data on the number of chest x-rays GPs request. In some parts of the country, there is a 10-fold variation in requests for chest X-ray by GPs. Ultrasound use also varies significantly. NCAT is producing GP practice profiles and PCT performance profiles. Trust-level profiles for breast and colorectal will be available in December 2011.

CCG focus group participants said that they would like information on options for service improvement to be available in standardised business case formats, including economic analysis

of different interventions. 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 would aid decisions on an ‘invest to save’ basis.

National standards, including NICE *Improving Outcomes Guidance* will underpin effective commissioning and continue to be a fact of life for commissioners and providers.

Build, share or buy?

Moving forward, CCGs will be in the driving seat. They will need to consider 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 have more management budget to build in house commissioning support but complex pathways of care like cancer will require CCGs collaboratively with other CCGs and with the NHS Commissioning Board as the spectrum of commissioning for cancer will span wider populations than an individual CCG.

Within cancer commissioning, the opportunities for CCGs to share commissioning support functions creates the chance for cancer networks to redefine their future role.

For instance, whilst recognising that as statutory organisations with clear clinical leadership but also with clear accountability, individual CCGs would remain unambiguously legally responsible for quality, outcomes and spend, CCGs across a network might agree to delegate authority to a trusted network to lead cancer commissioning. Alternatively, they could choose to delegate to

a local 'lead' CCG, each with a clear mandate about what the network or CCG is doing on the others behalf.

Agreeing any formal arrangements for delegated responsibility for commissioning cancer care and a CCG lead early on enables commissioning and improvement work to continue despite the transition so that CCGs maximise progress. Collaboration and joint working between cancer leads could seed region-wide approaches that increase commissioning clout and negotiating power with providers. Region wide approaches could also help reduce variations in cancer pathways and associated outcomes.

Cancer networks need to start involving CCGs now. As networks tend to have a significant secondary care focus and have operated in slightly different ways, participants felt it was hard to recommend one future network model. However, they were united in recognising that CCGs and networks need to start that conversation quickly as part of transition and CCG development planning and any future network model would be CCG led and focused.

Commissioning at the right level for different cancers

Significant progress has been made over the last few years in determining the appropriate population base for commissioning cancer services, given the incidence of cancers and the cost and complexity of care; as well as the mix of tertiary and secondary care necessary. CCGs would therefore helpfully be supported by cancer networks in developing a 'matrix of commissioning' for their local patch that would clearly outline the level at which commissioning of cancer care, should be undertaken given the evidence base and guidelines such as IOGs and the cancer strategy that CCGs will need to have reference to.

Clinically led cancer commissioning

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

The current reforms are predicated on clinically led commissioning and front line clinicians contributing their insight and knowledge of the local community to the commissioning process so they feel a greater sense of ownership of the outcomes.

CCGs will have a legal duty to support the NHSCB to drive up the quality of primary care. Whilst management of cancer care has not historically been a big part of GP providers' case load, achieving early diagnosis is going to be one of many future competing priorities.

CCGs need to develop a compelling narrative to engage their member practices in a push to improve early diagnosis. Clinical engagement of GPs in the cancer commissioning process will help achieve this.

There are GPs with a special interest in cancer around the country. CCGs need to identify these individuals and work with them to spread the message.

Clinical networks are potentially an important player in how effective clinical commissioning can be realised. They are an existing asset and will continue, hosted by the NHSCB but should be seen as a helpful 'enabler' for CCGs and CCGs should think about how they would wish to work with their existing networks. . However, there does still remain a number of issues to finally resolve, for eg although hosted by the NHSCB, what does this mean for CCGs, how they will be funded; or how they relate to proposed clinical senates. These are issues that need to be discussed and worked out.

Networks understood that delivering QIPP and value for money was a key priority for CCGs. They felt they could add value by supporting CCGs decisions on where to focus commissioning decisions. They also felt comfortable with being asked to drive disinvestment; although appropriate governance was seen as crucial. Developing for their CCGs the '10 high impact QIPP changes in relation to cancer care' was seen as something to be valued and welcomed.

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The role of Health & Wellbeing Boards

Responsibility for commissioning screening - as opposed to early diagnosis - the role of Health and Well Being Boards and public health is currently under discussion. Public Health England will be responsible for the provision of screening services and the prevention of smoking, alcohol.

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 prevention.

Commissioning is not just contracting

In the past, NHS commissioning in PCTs has often focused too much on the narrow aspect of contracting, technical issues and performance management. Contracting at CCG level would be inefficient given the ongoing downward pressure on management cuts and the likely number of CCGs. Each CCG will not have sufficient running costs to allow them to undertake all their commissioning by themselves. CCGs' management budgets won't stretch to this expertise. However, CCGs need to get contract specifications right to ensure focused performance management that delivers accountability and is aligned with CCGs' commissioning objectives and not what secondary care wants to provide; NICE guidelines and the NHS outcomes framework.



THEME TWO: BUILDING ON EXISTING ASSETS

The value of corporate memory

One of the biggest challenges CCGs face is retaining corporate memory and ensuring that they know what is happening already; what work has been done in the past and what improvement and service development work is already underway.

The Department of Health recognises this. That is one of the reasons why the cancer networks will continue, hosted by the NHS Commissioning Board (NHSCB).

Getting to know you

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

CCGs participating in our focus groups had very varied levels of understanding and knowledge about the role of cancer networks. Some GPs actively involved in clinical commissioning did not even know that cancer networks exist; and many did not know what they did. Likewise, few of those active in cancer networks understood CCGs and the challenges they face.

There is a significant opportunity for cancer networks and CCGs to learn from each other and build on their complimentary expertise and assets so that they reinvigorate commissioning and improve cancer outcomes.

CCG leads shared that whilst they recognised cancer was important, it was just one of many competing priorities – and that it was critical that cancer networks understood clinical commissioning so that they could support CCGs in constructive, concise and accessible ways that resonate with busy front line clinicians. CCG leaders suggested short summary documents, with links to sources of more information about networks’ existing capacity and skills would be a helpful introduction.

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

Networks as honest brokers

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

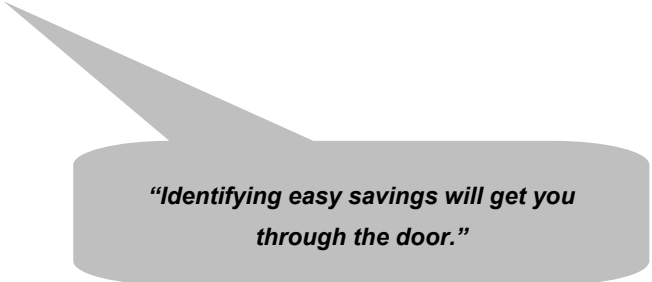
Cancer networks are currently perceived positively; as facilitators and enablers that spread good practice and encourage peer learning across the NHS.

The need for cancer networks has endured for over a decade - and there is still a major change programme to deliver in cancer care. Participants identified the potential role of networks as honest brokers who could facilitate collaborative working between commissioners and providers; support quality improvement within providers and share how best to achieve improved outcomes.

If networks successfully respond to change and begin to occupy this space, CCG leaders felt that some health economies might decide to delegate responsibility to networks and a central support role in cancer commissioning that CCGs could then champion with NHSCB. This might encompass: assessing population need and co-ordinating improvement in early diagnosis and acute oncology services.

Participants warned of the potential risk to networks’ reputations of being hosted by the NHSCB. This could see them written off as by CCGs as an outpost of NHSCB whose role is linked to performance management. CCG leaders felt that this link might undermine networks’ bid to be seen as independent and potentially central to improving cancer services across multidisciplinary teams.

THEME THREE: INNOVATION IN SERVICE PROVISION



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

Some of the aspects of the current annual £6 billion spend on cancer care remains inefficient. Clinical commissioning needs to disinvest in hospital based care and prevention of emergency admissions and redirect investment towards earlier diagnosis and better support for diagnosed cancer patients through outpatient care and ambulatory services.

In cancer care, there will be three key drivers for service change:

- Downward pressure on the NHS payment by results tariff, which does not yet apply to all aspects of cancer care
- The introduction of competition through the Any Qualified Provider (AQP) policy, designed to create plurality of service provision and person-centred care
- The changing nature of cancer care, including specialisation in regional ‘supra-network services’ and the delivery of chemotherapy and other interventions in outpatient and community settings.

Service re-design: a necessity in cancer care

CCGs face tough and necessary decisions about service re-design. Participants acknowledged that people know there is a compelling case for change and have done for some time. For instance, much breast cancer surgery could be done as overnight surgery and enhanced recovery programmes for inpatient care maintain quality of care and reduce a colorectal cancer hospital stay, for instance, from

10-14 days down to 4 days –or even less in some centres of excellence. Improved models of follow-up care are appropriate for most tumour types for example breast and prostate cancer improve patient experience and reduce cost.

The role of more personal self care planning and management of their condition was highlighted as an important aspect of any service re-design. Participants all felt that transferring aspects of cancer care to settings closer to home - when it is clinically safe to do so - offered both financial and quality benefits.

Re-design needs to be managed well. Best practice shows that engaging early with all stakeholders is key. All re-design decisions need to be based on robust evidence and demonstrate how they will improve clinical care. Cancer networks can help support re-design.

Decommissioning and disinvestment

Whilst people acknowledged that ‘seed corn investment’ supports innovation, ultimately there is a limited financial envelope. Clinical commissioning has to deliver savings in cancer care to free up funding for early diagnosis.

Everyone needs to acknowledge that fundamental change is necessary. Providers need to work collaboratively as part of the clinical commissioning team. Cancer networks can help map the future and facilitate change

RECOMMENDATIONS FOR STAKEHOLDERS

- 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;** CCGs will be held to account for their share of the Government's 5,000 lives target. As well as NHSCB, the public and politicians will ask questions if they fail to deliver.
- **Appoint a named CCG cancer commissioning lead;** a GP with a commissioning interest rather than one who specialises in cancer care to liaise with other CCGs and the local cancer community. Work together, using existing best practice to identify the likely right approach to commissioning locally for key cancers
- **Link early and join forces with cancer networks.** Include them in your thinking; tap in to their expertise and the resources they bring to the table. While most will have one cancer network some CCGs will need to redesign pathways across 2-3 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. Find out the NCAT recommended level of population for commissioning and design commissioning processes accordingly. Specialist commissioning will remain. Work with specialist commissioners and share expertise
- **'Build', 'share' or 'buy'** elements of cancer commissioning support such as data analysis so that you maximise value for money and quality. View cancer networks as assets and work with their expertise
- **Use existing data to its full potential;** NCAT and NCIN produces profiles of GP practices and providers' performance. Reassure member practices that this is not performance management data
- **Work with PCT clusters and providers to gather commissioning data;** identify gaps early and ways to complete the picture so that you have a good overview of current strengths and weaknesses in the system and population need
- **Work up the business case for disinvestment** in secondary care of cancer through reduced length of stay post surgery and improved community based services to improve outcomes and quality for patients. Establish unambiguously where you and PCT clusters stand in relation to current spend and budget for cancer care
- **Work up the business case for investment** in improved diagnosis and prevention in primary care for example smoking cessation, obesity and alcohol
- **Develop a compelling narrative and engage GP colleagues** with their contribution to delivering improvement - especially in relation to early diagnosis. Whilst acknowledging that GP colleagues are balancing cancer with many other competing priorities - including primary care access requirements - recruit GP practices to be actively involved in cancer care. Many are unaware of their pivotal role in improving outcomes. Engage GPs with a special interest in cancer in this process as champions for change

Quick Wins for Commissioning High Quality Cancer Services: Recommendations from the Frontline

- **Target screening programmes at high risk groups** to drive early diagnosis. Working closely with Health and Wellbeing Boards, target screening and related awareness campaigns at the highest risk groups. Work closely with public health to identify high risk groups and design effective ways of engaging these communities
- **Think integration** - cancer commissioning need to be joined up across CCGs to ensure integration - especially in light of a range of qualified providers working within a patch. Cancer care is complex and needs end-to-end co-ordination of care pathways. This is a key skill that cancer networks bring to the table.

Recommended actions for providers

- **Appoint a cancer care lead** to liaise with CCGs and work on reconfiguration plans
- **Work collaboratively with CCGs to redesign cancer care**; change will work best if providers and CCGs work collaboratively to develop safe, financially sustainable services that recognise and manage the consequences of disinvestment for providers
- **Put in place a feedback and learning system to support GP referral**; supportive feedback could help GPs to improve the quality of referrals to secondary care. 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**; now is the time to initiate redesign of cancer services. Objectively review current service models in the face of imminent disinvestment. Examine the length of cancer inpatient stays and outpatient follow up; follow NICE guidelines and focus on delivering improved outcomes.
- **Focus on community based care**; prepare to shift services into primary care and increase capacity for screening and early diagnosis.
- **Gather feedback from people using services** about what works well and what can be improved.

- **Work with people with experience of cancer** and CCGs to create new thinking and innovative approaches to delivering redesigned, cost effective, high quality of cancer care.

Recommended actions for networks

- **Appoint a named network lead to link with CCGs**
- **Engage directly with CCG leaders now**; cancer networks need to engage as a priority. Use websites to post 'top tips' for CCGs and related information that show the value networks add
- **Proactively communicate current cancer strategy** to all new commissioners and providers across the network. With significant changes to the structures of the NHS, people need simple descriptions of the current arrangements for cancer pathways. These could include refreshed strategic plans and local patient pathway 'flow charts' that preserve corporate memory
- **Ensure co-ordination of messages across other clinical networks**; for example stroke and CHD prevention, rehabilitation and palliative care are other areas of overlap which need to be fed into the CCGs in a co-ordinated way.
- **Highlight the value of networks as facilitators and 'honest brokers'**; cancer commissioning is complex, specialised work. Networks' experience, knowledge and understanding makes them obvious candidates for taking on cancer commissioning at scale to maximise efficiency and maintain quality
- **Use patient stories as a learning tool**; regularly and systematically assessing patients' experiences of care and feedback reminds clinical teams and commissioners of the importance of being person centred. Patient stories are a powerful learning tool for service improvement, sense-checking and redesign and important hooks to attract clinicians' attention. Most cancer networks have long-standing arrangements for involving patient groups. Their experience and input can be invaluable in shaping care pathways.

- **Add value to data and proactively work with CCGs;** CCGs want granular provider performance data and no surprises. Networks have lots of data. This data needs to be turned into information and intelligence. By defining key data sets, built from peer review, networks could help CCGs create powerful local dashboards, which are clinically owned. Networks can also help CCGs to understand service and commissioning data and work out how best to configure commissioning for different cancers
- **Support CCG leads to develop and deliver business cases;** change is essential. The focus needs to be on the health economy as a whole - rather than sustaining providers and the status quo. A guide on where to invest - and crucially where to disinvest - would be helpful. Cancer networks can help CCGs with business cases and support conversations with providers as honest brokers.
- **Explore sustainable and lean commissioning support models;** prove value by marketing data, intelligence, experience and services to clinical commissioners. Because clinical commissioners have limited time, publications should be snappy - 3 sides of A4 - with links to more in depth information online
- **Stand in the shoes of CCGs** when designing information and commissioning support offers. Remember the competing clinical commissioning priorities GPs face. Be creative about how to deliver support in timely, accessible ways e.g. on line and in summary format
- **Promote peer review;** peer review is seen as a key benefit of networks; albeit rather structure- and process-driven. Focus future peer review on improving clinical outcomes and highlight to providers areas of potential concern and immediate risk - as well as how their services are performing more generally compared to peers and national standards.

Recommended actions for National Cancer Action Team

- **Create accurate costs for the whole cancer pathway.** Make them granular and based on provider cost bases. Accurately costing whole cancer pathways to support commissioning is challenging; progress in breast and colorectal cancer care is helpful. CCGs want more of the same and a very granular understanding of costs.
- **Continue development of performance dashboards** to give CCGs an accurate one glance overview. NCAT's current prototype data tools for commissioners, networks and providers - like service profiles for each multidisciplinary single-cancer team, offering a review of the pathway; patient experience; and 'headlines at a glance' so commissioners can see if things are broadly on track – are useful.
- **Create data sets to help CCG benchmark against their peers;** benchmarking profiles and data like that produced on GP practices, PCTs and provider helps people understand how they compare with others across a range of metrics and are very helpful
- **Improve health economic appraisal;** offer more 'ready-made' health economic appraisals on changes in care configuration and an evidence-based list of 'early wins' where service changes would lead to savings. Explain how savings might be made - i.e. cost savings from early diagnosis – with evidence to back up the appraisal
- **Define appropriate population bases for commissioning** for specific tumours in line with emerging evidence and changing technology. Work with cancer networks and NCIT to develop the rationale and evidence base for commissioning treatments for certain tumours at certain population sizes in line with evidence and changing technology

Quick Wins for Commissioning High Quality Cancer Services: Recommendations from the Frontline

- **Develop a set of 'Desert Island Metrics'**; the top 5 indicators that give a good indication on cancer performance plus the 5 questions everyone 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 resource - 'High Impact Changes for Cancer Commissioning'**- outlining evidence-based early wins. CCG leaders and colleagues in networks and providers want an evidence-based list of early wins where service changes would lead to savings; ideally including examples where it has worked. Various participants described this as a list of cancer commissioning 'high-impact changes'
- **Raise awareness of enhanced recovery**; CCGs know little about enhanced recovery. NCAT should raise awareness of the evidence base for enhanced recovery schemes 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 the right culture** that recognises risk and supports CCGs to drive service reconfiguration. Cancer care is a politically sensitive issue. Reconfiguring cancer care will involve doing things differently – and this means risk. Enable CCG leaders to 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 payment by results (PBR) tariff. If data are not provided, it should mean no PBR payment.

Recommended actions for the Pharmaceutical Industry

- **Build on pharmaceutical providers' experience, expertise and resources** through transparent relationships that focus on the patient. In the spirit of the ABPI and DH interactive toolkit for joint working between the NHS and the pharmaceutical industry published last year, build on opportunities for industry to bring their experience, expertise and resources to the table within the context of transparent relationships with CCGs, networks and providers to address shared agendas
- **Mirror best practice in partnership working**; Learn from examples of joint working like the Pharmaceutical Oncology Initiative Partnership, NCAT and NHS Improvement who collaborated on the web based Chemotherapy Planning Online Resource (C-PORT), which has been implemented in most cancer networks and over 100 hospitals
- Extend joint working to initiatives to early diagnosis and community based service delivery e.g. developing business cases for investment in ambulatory chemotherapy, enhanced recovery schemes out in the community to improve patient outcomes, necessary service redesign in hospital based care and supporting other efficiencies.

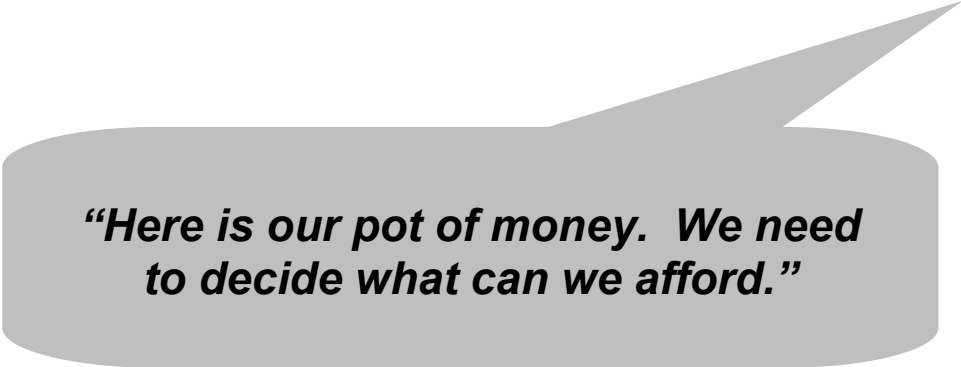
In conclusion, when it comes to cancer commissioning, CCGs are definitely in good company. Whilst they face many competing priorities, making a few early decisions and most importantly, appointing a clinical commissioning lead will kick start action and set CCGs on the road to improving cancer outcomes. 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.”



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



“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”



**QUICK WINS FOR COMMISSIONING
HIGH QUALITY CANCER SERVICES:
Recommended Actions from the Frontline**

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