

# cancer commissioning guidance

Welcome to the Cancer  
Commissioning Guidance  
supporting world-class commissioning  
of cancer services

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<b>Document purpose</b>	Best Practice Guidance
<b>Gateway reference</b>	9935
<b>Title</b>	Cancer Commissioning Guidance
<b>Author</b>	Teresa Moss, National Cancer Action Team, et al
<b>Publication date</b>	22 December 2008
<b>Target audience</b>	PCT Chief Executives, PCT PEC Chairs, SHA Chief Executives, Cancer Network Directors.
<b>Circulation list</b>	
<b>Description</b>	The Cancer Commissioning Guidance highlights aspects of World Class Commissioning Assurance Framework including organisational competencies for cancer commissioning. It also sets out key issues and questions that commissioners/network teams should consider when assessing health needs; reviewing services; developing contract service specifications; and monitoring performance.
<b>Cross ref</b>	Cancer Reform Strategy
<b>Superseded docs</b>	
<b>Action required</b>	N/A
<b>Timing</b>	N/A
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283527 1k Dec 2008

Produced by COI for the Department of Health

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## Welcome to the NHS Cancer Commissioning Guidance

This Cancer Commissioning Guidance, announced as part of the Cancer Reform Strategy (DH, December 2007) has been developed by the National Cancer Action Team (NCAT) in order to support world-class commissioning of cancer services across the NHS.

The Guidance sets out, in an easy-to-use format, key issues and questions that commissioners and cancer network teams will want to take into consideration when assessing health needs, reviewing services, developing their contract service specifications and monitoring performance.

The guidance will be updated on an ongoing basis to ensure that it remains relevant and up to date.

The Cancer Commissioning Guidance sits alongside the linked, web-based Cancer Commissioning Toolkit (CCT).

CCT provides an easily accessible, 'one-stop' source of cancer information with a range of metrics selected and benchmarked to answer some of the key commissioning questions raised by the Cancer Commissioning Guidance. The aim is to support commissioners and cancer network teams in their strategic planning and prioritisation, enabling them to lead change and innovate locally, based on best clinical evidence. The benchmarked information provided within CCT will inevitably prompt further questions, but it is hoped that it will act as a catalyst for intelligent discussion between commissioners, local providers and the local population.

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## 1. Introduction

The Cancer Reform Strategy was published by the Government in December 2007 and set out the next steps for delivering cancer services in England. It recognised that good progress has been made in improving services since the publication of the NHS Cancer Plan in 2000, but that significant challenges remain if cancer services in England are to reach the goal of not only being among the best in Europe but among the best in the world by 2012.

Stronger commissioning is a vital cornerstone for delivering this goal and the Department of Health published its vision for World Class Commissioning (WCC) in December 2007. There are four key elements to the work being taken forward by WCC with Primary Care Trusts (PCTs):

- a focus on improving health outcomes and reducing health inequalities
- the organisational competencies that a world-class commissioner will need
- a single assurance system, managed by Strategic Health Authorities (SHAs), with three components: health outcomes, competencies and governance
- support and development.

Further information can be found at:

[www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm](http://www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm).

The National Cancer Action Team (NCAT) is working with the Department of Health World Class Commissioning Team to support the step-change that PCTs and their cancer network teams will want to make in commissioning cancer services.

This Cancer Commissioning Guidance (CCG) is part of a suite of products to strengthen commissioning skills and knowledge. It is designed to be in two parts:

- i The first section will highlight aspects of the WCC Assurance Framework, including the organisational competencies that those involved in cancer commissioning will want to focus on.
- ii The second section sets out key issues and key questions commissioners/network teams will want to take into consideration when assessing health needs, reviewing services, developing their contract service specifications and monitoring performance. The chapters relate to sections contained in the Cancer Reform Strategy.

The first section is to follow.



It is important to acknowledge that this guidance will need to be refreshed and developed over time, particularly in the areas of continuing national work signalled in the Cancer Reform Strategy.

In addition, a web-based Cancer Commissioning Toolkit (CCT) is now available. The toolkit provides an easily accessible, 'one-stop' source of cancer information to overcome the challenge that national published information on cancer is currently held in different places (Cancer Registry, cancer screening services, Hospital Episode Statistics, cancer peer review, programme budgeting, bespoke national analyses etc.). The CCT brings this information together into a single, web-based product. Metrics have been selected and benchmarked to answer key commissioning questions.

The aim is to support commissioners and network teams in their strategic planning and prioritisation, enabling them to lead change and innovate locally, based on best clinical evidence. The benchmarked information in the CCT will inevitably prompt further questions, but it is hoped that it will act as a catalyst for intelligent discussion between commissioners, local providers and the local population.

Throughout both this commissioning guidance and the toolkit there are links to policy and guidance documents as well as to the NHS Improvement website. This is to ensure that PCTs and networks have ready access to best practice examples of service innovation. We will continue to build this library and welcome suggestions.

The NCAT and National Cancer Intelligence Network will support PCTs, cancer networks and other stakeholders to use the toolkit and will continue to work with them on further refinements and developments. It is hoped that by making more use of the information that is available, data accuracy will improve year on year. Significant support in developing the information has come from the National Cancer Statistical Analysis Team, as well as the Cancer Registries and cancer screening programmes.

A further important strand of work is being led by cancer network teams across the country. This is the development of model service specifications for each cancer pathway, which will be available on the Map of Medicine (MofM). MofM offers high-quality clinical information, linked to the NHS IT programme.

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The Network Development Programme (NDP) recommended colorectal pathway' is already on the MofM and this, together with an overall methodology and governance framework, has been developed by the North East London Cancer Network and MofM and supported by the National Institute for Health and Clinical Excellence (NICE). It is anticipated that model disease pathways and service specifications for the main cancers will be available on the MofM by early 2009 to support the next round of contracting. Individual cancer networks are leading on the development of different pathway(s), within an agreed framework for sign off that includes NICE. Cancer network teams are working closely with 18-week clinical and managerial leads at local health community level to ensure harmony with the redesign of 18-week commissioning pathways. This will ensure that patients referred as non-urgent but who have cancer are 'red flagged' at the appropriate part of their pathway.

Workstreams to support stronger cancer commissioning will continue to be developed by the NCAT in partnership with the Department of Health World Class Commissioning Team and other national and local stakeholders. We hope this guidance will support PCTs and cancer networks to take forward the implementation of the Cancer Reform Strategy.

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## 2. The challenge of cancer

### 2.1 Cancer incidence, mortality, survival and inequalities – undertaking a strategic needs assessment

#### 2.1.1 Key issues

- cancer is the biggest cause of premature death among people aged under 75 in England (38%, compared with 28% from circulatory diseases and 9% from respiratory diseases)
- even in areas with lower than average incidence and mortality, e.g. because of an unusually young population, cancer is still either the most common or the second-most common cause of death
- cancer mortality among those aged under 75 years fell by more than 17% between 1995 and 2005. This equates to 60,000 lives saved during this period
- survival rates for breast and bowel cancers are improving year on year in England, in line with other European countries, but our relative position has not improved
- the incidence of cancer continues to rise due to population growth and the ageing population, and it is predicted to increase by around one third between 2001 and 2020. Predicted national increases are set out in Møller, H., Fairley, L., Coupland, V. et al

- this overall increase in incidence conceals several changes in the incidence of individual cancer tumour sites
- over the next 10 years, as outcomes of treatment improve and there are more long-term survivors, late effects of treatment will begin to have an increasing impact on associated morbidity and mortality
- as the population ages, the individual risk of cancer, which now stands at around 30%, may well rise to 40%
- over half of all cancers are preventable, with smoking being the largest preventable cause of death
- obesity is now the most preventable risk factor for cancer in non-smokers.

#### 2.1.2 Background

The first stage in cancer commissioning is to know your population. Local Authorities and Primary Care Trusts (PCTs) now have a new duty, under the Local Government and Public Involvement in Health Act 2007, to undertake a Joint Strategic Needs Assessment (JSNA) of the health and well-being needs of the local community.

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Priorities identified in the JSNA should guide the development of local area agreement targets for a three-year period from 2008. These agreements will be taken forward by Local Strategic Partnerships (LSPs). The LSP will act as an enabler for the funding of prevention, early detection and inequalities initiatives.

Cancer networks, through their PCTs, should work to inform the JSNA, as well as be informed by its findings. For example, the JSNA will help to identify communities or groups that are at risk of cancer on account of lifestyle choice, or that have problems accessing services due to transport problems or overall deprivation.

Two relevant guidance documents on the local performance framework and the indicators that health and social care organisations are interested in are:

- delivering health and well-being in partnership: The crucial role of the new local performance framework
- guidance on Joint Strategic Needs Assessment.

### 2.1.3 Needs assessment

Issues to take account of when assessing population needs are:

- demographic trends: an increasing elderly population
- smoking
- other lifestyle risks such as obesity, diet, lack of physical exercise, excess alcohol and exposure to sun/sun beds
- ethnicity
- access: deprivation, age, disability and ethnicity.

These issues are covered below:

#### *Demographic trends: an increasing elderly population*

- the biggest risk factor for cancer is increasing age. Population demographics and the proportion of older people in the community will be the key determinants of the burden of cancer, impacting on:
  - acute care (the total incidence of cancer)
  - palliative care in hospital and the community (the need for palliative care can be estimated from the number of cancer deaths).

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Incidence, survival at one and five years, mortality rates and trends should be explored for the four most common cancers (breast, lung, prostate and colorectal) at PCT level, although it is worth noting that survival data for prostate cancer are not regarded as a guide to the quality of treatment, since they are largely influenced by prostate-specific antigen (PSA) testing practices.

It is important to note that in small populations of below 100,000 there may be considerable variation year on year in the incidence of cancers, but at a large PCT or cancer network level there is considerable stability in total cancer incidence, albeit with an upward trend of approximately 2% growth each year. The use of three-year rolling averages at a local level will help to smooth out trends.

*Smoking and other lifestyle risks, such as alcohol*

- smoking is the biggest avoidable risk factor. High smoking rates – particularly in deprived communities, certain black or minority ethnic (BME) communities and the gay community – lead to a higher incidence of cancer. The key cancers attributable to smoking include lung (85% attributable to smoking), bladder (50%) and renal (30%)

- for certain cancers, e.g. head and neck and upper gastro-intestinal cancers, the risk from smoking is increased if accompanied by heavy alcohol consumption
- mesothelioma is a less common cancer, but is geographically focused on certain areas with large numbers in occupations that have exposed them to asbestos (e.g. dockyards). The risk of cancers related to asbestos exposure is accentuated by smoking. Incidence of mesothelioma will peak in around 2011 to 2015
- smoking cessation has been greater in more affluent communities, which has tended to widen inequalities
- excessive alcohol consumption is linked to mouth, larynx, oesophagus, liver and breast cancers (Safe. Sensible. Social. The next steps in the National Alcohol Strategy)
- sexual behaviour is the major risk factor for cancer of the uterus and cervix and increasingly for anal cancer and some head and neck cancers (due to oral herpes)
- postponement of pregnancy is a risk factor for breast cancer and also, though less so, for ovarian and uterine cancers.

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### *Obesity and lack of physical exercise*

- there is increasing evidence of the link between obesity and cancer. For instance, the Million Women Study has reported significantly higher rates of most cancers, but especially of post-menopausal breast cancer and endometrial cancer in obese or overweight women
- there is also good evidence that high body fat significantly increases the risk of renal cancers and adenocarcinoma of the oesophagus in both sexes and of colorectal cancer in men
- an avoidable excess of 5% of all cancers – 6,000 annually – is attributable to high body mass index (BMI). Obesity (high BMI) is linked to deprivation
- physical activity is associated with a reduction in the overall risk of cancer, has a clear protective effect on colon cancer and is associated with a reduced risk of breast cancer in women after the menopause. Further details can be found in Chapter 5 of the Chief Medical Officer's 2004 report on the impact of physical activity on health.

### *Excessive exposure to ultraviolet light*

- melanoma rates are rising rapidly, as increasing affluence leads to over-exposure to sun on foreign holidays. It is also due to the use of sun beds on a regular basis. Global warming may impact on this even further.

### *Access: deprivation, age, disability and ethnicity*

- deprived patients are less likely to attend for screening programmes and tend to present with more advanced disease at diagnosis. Note that small pockets of deprivation, and therefore population need, can be masked if they lie within relatively affluent areas
- access to services will depend not only on an individual patient's disability or the level of deprivation but also on the geography of the area, road infrastructure and transport links
- long travelling times to chemotherapy and radiotherapy services can place a heavy burden on patients and result in considerable expense. Assessing what proportion of the population has access to a car is important. If access is not convenient, patients may choose less optimal treatments in order to avoid travel, such as mastectomy rather than lumpectomy followed by

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radiotherapy. The National Radiotherapy Advisory Group (NRAG) report recognises the usefulness of satellite radiotherapy facilities for improving access where significant concentrations of population have journeys of more than 45 minutes to their nearest radiotherapy service

- older patients might not be offered appropriate treatment by their doctors.

#### *Ethnicity*

- some cancers appear to be more common in certain ethnic groups, such as prostate cancer in men of African or Afro-Caribbean origin
- sometimes there are identifiable lifestyle risks; for example, the chewing of tobacco is linked to increased oral cancers in South Asian populations
- screening uptake is also lower in BME groups, due to a combination of linguistic and cultural barriers and a lack of perception of risk and the benefits of early detection.

#### **2.1.4 Where to get more information on your population**

The Association of Public Health Observatories (APHO) website includes health profiles by Local Authorities, at both district/borough and county levels, which provide a consistent, concise, comparable and balanced overview of the population's health to inform local needs assessment, policy, planning, performance management, surveillance and practice. There is also a summary of the most useful available health indicators, together with data on economic factors and ethnicity. In addition, there is a series of reports on indicators for specific health issues, including alcohol, ethnicity and lifestyle factors, together with summaries of all indicators by region. APHO has also done some work on disease prevalence models for hypertension and coronary heart disease to inform planning in 2007/08.

The Public Health Observatory Handbook of Health Inequalities Measurement and the health poverty index provide further useful information.

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Key commissioning questions for needs assessment	Where to find the answers
What is the all-age, all-cause mortality rate in your PCT?	Public Health Observatory/local public health network
What is the mortality from all cancers at age <75?	Public Health Observatory/local public health network
What is the healthy life expectancy at age 65?	Public Health Observatory/local public health network
What is the prevalence of smoking among those aged >16?	Public Health Observatory/local public health network
What proportion of the local population is aged over 65, and what proportion is aged over 75?	Public Health Observatory/local public health network
What percentage of the population is employed?	Public Health Observatory/local public health network
What percentage of the population is on benefits?	Public Health Observatory/local public health network
What is the ethnic mix of the population?	Public Health Observatory/local public health network
Which are your more deprived wards?	Public Health Observatory/local public health network
How good are public transport links to your local cancer unit and centre – especially from more deprived communities and areas with high concentrations of older people?	Local knowledge

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## 2.2 National indicators

There are a number of national indicators of interest to health and social care organisations published in Delivering health and well-being in partnership: The crucial role of the new local performance framework.

The following national indicators are those most relevant to cancer. Most are also based around the Operating Framework Vital Signs. Under the World Class Commissioning framework, PCTs are being asked to select eight indicators from Tier 3 Vital Signs where they particularly want to improve services.

### National indicators relevant to cancer

Safer communities	
NI 39	Alcohol harm-related hospital admission rates (Tier 3 Vital Signs)
Adult health and well-being	
NI 120	All-age, all-cause mortality rate (Tier 2 Vital Signs)
NI 122	Mortality from all cancers at ages under 75 (Tier 2 Vital Signs)
NI 123	Current smoking rate prevalence in routine and manual groups among those aged 16 and over (Tier 2 Vital Signs)
NI 128	User-reported measure of respect and dignity in treatment (Tier 3 Vital Signs)
NI 129	End-of-life access to palliative care, enabling people to choose to die at home/proportion of all deaths that occur at home (Tier 3 Vital Signs)
NI 131	Delayed transfers of care from hospitals per 100,000 population (aged 18 and over)
NI 132	Timeliness of social care assessment (Tier 3 Vital Signs)
NI 134	Number of emergency bed days per head of weighted population (Tier 3 Vital Signs)

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Adult health and well-being (continued)	
NI 135	Carers receiving needs assessment or review and a specific carer's service, or advice and information
NI 137	Healthy life expectancy at age 65 (Tier 3 Vital Signs)
Tackling exclusion and promoting equality	
NI 55	Obesity among primary school age children (Tier 2 Vital Signs)

### 2.3 Cancer Commissioning Toolkit metrics

The Cancer Commissioning Toolkit contains the following metrics that relate to this chapter. These can be found by accessing the corresponding chapter, **Cancer Landscape**, and the sections **Challenge of Cancer** and **Cancer Prevention**, either via the dashboard or the contents page.

#### Challenge of Cancer

- age-standardised incidence
- actual incidence
- age-standardised incidence, time trend
- actual mortality
- five-year rolling average (age-standardised) mortality
- five-year rolling average (age-standardised) mortality, time trend
- % change in mortality rates since 1997
- % change in mortality rates since 1997, time trend
- one-year survival rates benchmark
- five-year survival rates benchmark
- survival rates, time trend.

#### Cancer Prevention

- % successfully quit smoking at four weeks
- % successfully quit smoking at four weeks, time trend
- actual number setting quitting date and quitting smoking after four weeks
- rate of smoking quitters per 100,000 population aged 16 and over, time trend.

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## 2.4 Primary Care Trust operating plans

PCTs will have now agreed their operating plans for 2008/09–2010/11. The plans include national requirements, national priorities and local actions – ‘Vital Signs’ – that will be monitored by PCTs and SHAs. Those of particular interest for cancer are shown below. A full list is available (see ‘Useful links’ on the menu bar).

### Summary of Tier 1 Vital Signs for cancer and delivery timescales

Proportion of patients with breast symptoms referred to a specialist who are seen within two weeks of referral.	All patients by December 2009.
Proportion of women aged 47–49 and 71–73 offered screening for breast cancer.	NHS Breast Cancer Screening Programme will be extended to all women aged between 47 and 73 by 2012.
Proportion of men and women aged between 70 and 75 taking part in the NHS Bowel Screening Programme.	NHS Bowel Cancer Screening Programme will be extended from 2010 to invite men and women aged 70–75 to take part.
Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (surgery and drug treatments).	Patients wait no more than 31 days from the decision to treat to the start of treatment extended to cover all cancer treatments by December 2008.
Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments).	Patients wait no more than 31 days from the decision to treat to the start of treatment extended to cover all cancer treatments by December 2010.
Proportion of patients with suspected cancer detected through national screening programmes or by hospital specialists who wait fewer than 62 days from referral to treatment.	All patients with suspected cancer detected through national screening programmes or hospital specialists wait no more than 62 days from referral to treatment by 2009.

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### Summary of Tier 1 Vital Signs for cancer and delivery timescales (continued)

Proportion of women receiving the results of their cervical cancer screening tests within two week	All women should receive the results of their cervical screening tests within two weeks by 2010.
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### Summary of Tier 2 Vital Signs for cancer and delivery timescales (where applicable)

Cancer mortality rate of those aged 75 and under.	
Smoking prevalence among people aged 16 or over and among those aged 16 or over in the routine and manual groups (local quit rates in 2008).	



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## 2.5 Commissioning guidance – links

Publication	Date of publication
Guidance on Joint Strategic Needs Assessment.	13 Dec 2007
Our health, our care, our say: a new direction for community services.	30 Jan 2006
Strong and Prosperous Communities – The Local Government White Paper.	26 Oct 2006
Local Government and Public Involvement in Health Act 2007.	2007
The New Performance Framework for Local Authorities and Local Authority Partnerships: Single Set of National Indicators.	11 Oct 2007
Commissioning framework for health and well-being.	6 Mar 2007
The Operating Framework for the NHS in England, 2008/09.	13 Dec 2007

## 3. Prevention

### 3.1 New and changing services

For the NHS to be sustainable in the 21st century it needs to focus on improving health as well as treating sickness. Our longer life span, the changing nature of disease and people's expectations are challenging the NHS to focus on its contribution to the prevention of ill health. In the consultation for the NHS Next Stage Review and the Next Stage Review final report, High Quality Care for All, nearly a quarter of people felt health was 'mainly my responsibility', and a further 60% felt it was 'mainly me with support from the NHS'.

We need to ensure that people have convenient access to prevention services – and that these are provided on 'an industrial scale'.

#### 3.1.1 Stop Smoking services and tobacco control

Stop Smoking support from the NHS is available to all smokers free of charge in all communities across England. Smokers who use NHS support are up to four times more likely to quit successfully than those trying to go it alone 'cold turkey'. Advice and support for quitting are also available to smokers through NHS help-lines and websites. Around 165,000 smokers quit with help from the NHS between April and September 2007 – an increase of 28% over the same period for the previous year.

The blueprint for the service is based on extensive research evidence. However, much more needs to be done to improve the impact of the treatment provided; to increase the range of approaches to be used to support smoking cessation for all groups of people and the settings in which treatment can be provided; and to ensure that anyone who wants support in quitting has equal access to the most appropriate treatment. Currently, some 5% of smokers report that they use the NHS Stop Smoking service each year.

A consultation on the future of tobacco control, including Stop Smoking services, took place, with a closing date of 8 September. Challenges raised in the consultation include:

- embedding a 'systems approach' to smoking cessation in primary care
- maximising brief interventions and referral to NHS Stop Smoking services in key health settings including primary care, pharmacy, antenatal and acute care

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- accelerating progress on embedding ‘stop before the op’ programmes and referral systems within acute care settings
- improving the consistency and reliability of data management and reporting within the NHS Stop Smoking services.

Tobacco control – not just Stop Smoking services or media campaigns in isolation, but an integrated package of interventions – has enormous potential to tackle health inequalities and the ongoing burden of disease caused by smoking. Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control provides best practice guidance for everyone involved in delivering services and programmes of work to prevent and reduce smoking in their communities.

### 3.1.2 Weight management services

The NHS Next Stage Review also highlighted weight management services as one of the prevention services that PCTs should increasingly commission. The national Healthy Weight, Healthy Lives strategy, published in January 2008, sets out a wide range of commitments to tackle childhood obesity. It recognises the importance of weight management services, which can provide vital support to overweight and obese individuals in reaching and maintaining a healthier weight.

A number of specific commitments in this strategy are currently being taken forward in order to support increased local commissioning of weight management services. In line with Healthy Weight, Healthy Lives, the initial focus is on children and includes:

- provision of new funding to local areas to take overall action on obesity over the next three years, with £65.9 million available in the current financial year
- publication of Healthy Weight, Healthy Lives: Commissioning Weight Management Services for Children and Young People, including tools to cover the key stages of the commissioning process
- development of a framework of providers to support local delivery of services.

The Cross-Government Obesity Unit is also developing plans to support local areas in commissioning weight management services for adults as part of the Healthy Weight, Healthy Lives strategy itself and to support the implementation of other national programmes such as vascular checks.

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### 3.1.3 Other prevention services

PCTs have been asked to commission comprehensive well-being and prevention services, in partnership with Local Authorities. The services offered should be personalised to meet the specific needs of their local population.

Other new initiatives, such as the vascular risk assessments and the accompanying national campaign 'Reduce Your Risk', have the potential to contribute to cancer prevention – as they will be focusing on overlapping risks such as smoking or obesity.

Key commissioning questions for prevention	Where to find the answers
What is the current performance on the smoking cessation target for the PCTs? How does this compare to similar areas?	Information Centre for Health and Social Care – statistics on NHS Stop Smoking services
Are there any geographic or population groups with high rates of smoking? Are services available to meet their needs?	Local Director of Public Health reports or health equity audits
Are Stop Smoking services sufficient to meet the local needs?	
Are other prevention services sufficient to prevent cancer?	
Does the incidence of skin cancer in your network or PCT warrant consideration of local investment in skin cancer prevention initiatives?	The Pathfinder Networks for skin cancer prevention are developing local initiatives with PCTs. Alongside this work, the South West Cancer Registry is bringing together information and evidence for cancer networks and PCTs. The results of this work and a National Institute for Health and Clinical Evidence evidence review will be available in 2009.

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## 4. Diagnosing Cancer Earlier: Awareness, Early Detection and Screening

### 4.1 Raising public awareness of cancer symptoms

In general, the earlier a cancer can be diagnosed the greater the prospect of a cure. However, public awareness of the main cancer risk factors and knowledge of the signs and symptoms of cancer remains relatively poor in England, especially among deprived populations and black and minority ethnic (BME) groups, and it is probable that this leads to patients presenting later with possible cancer symptoms.

While some cancers (breast, cervical, bowel) can be detected early by screening, most cancers cannot be screened for. Late presentation is regarded as one of the major reasons for poor outcomes among cancer patients in England. In addition, treatment of late-stage disease is often more costly than early diagnosis and treatment. The Cancer Reform Strategy recommends that PCTs should give a high priority to local initiatives to promote early presentation by people with symptoms which may be cancer, and Networks/PCTs will wish to monitor their progress in this area. To do this, PCTs will be able to use the tool developed to measure public awareness of the risk factors and symptoms of cancer at a local level to produce a benchmark and assess any subsequent changes.

Where evidence of low awareness and of late presentation is identified, commissioners should take appropriate action to remedy this. A variety of data sources – Cancer Registries, Public Health Observatories – are available to commissioners to assist with identifying relevant populations and targeting resources.

There are a number of areas PCTs can explore to determine whether late presentation with cancer is a problem in their population. These include:

- low one-year survival rates (in the absence of good staging data by hospital multidisciplinary teams (MDTs), low one-year survival rates can be used as a proxy indicator for late presentation) – these should be benchmarked with international rates, e.g. Sweden
- screening uptake across the PCT
- screening uptake by general practice – there is often variation
- two-week wait referral rates by general practice per 10,000 population – there is often wide variation
- numbers of cancers diagnosed through non-urgent routes – there is again variation across the country
- emergency admissions where cancer is diagnosed.

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The Department of Health has invested in a series of localised awareness-raising campaign pilots that use a social marketing approach; a definition of social marketing is available from the National Social Marketing Centre. The findings from these pilots will be available in 2009.

For campaigns such as these to be of maximum value, it is essential that they are evaluated and their findings disseminated. Commissioners need to ensure that their

service is up to date with the findings and apply the resultant methodologies where appropriate.

Commissioners should be aware that there are several social marketing organisations external to the NHS that can provide advice or develop a cancer awareness-raising programme for PCTs.

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Key commissioning questions for awareness and early detection	Where to find the answers
What is the level of cancer incidence in your PCT?	Cancer Information Service, Association of Public Health Observatories
What is the survival rate for cancer patients at one year in your PCT?	National Cancer Registries, The Office for National Statistics
Have you produced a health profile of your PCT? See The challenge on the menu bar.	Association of Public Health Observatories, Department of Health – Health Inequalities Branch, Cancer Registries
How many cancers are diagnosed through the non-urgent route (excluding screening)? How does this compare with other PCTs?	Cancer Waiting Times database, local analysis
What are the two-week wait referral rates across the PCT/by general practice per 10,000 population? How does this compare with national averages? Is there variation between general practices?	Cancer Waiting Times database, local analysis
What is the screening uptake (breast/cervical) across the PCT? Does it vary between general practices?	Screening data/Quality and Outcomes Framework data

## 4.2 Early detection of cancer by primary care professionals

Most patients who are diagnosed with cancer will have first presented to their GP with symptoms that are usually difficult to differentiate from less serious complaints.

A GP with a list size of 1,800 patients can expect to see only eight or nine new patients with cancer (one new case of breast, colorectal, lung and prostate cancer a year, and less common cancers, such as pancreatic, once every five or six years).

The National Patient Safety Agency (NPSA) has raised missed diagnosis of cancer as an important issue. It is, therefore, intended to establish a National Audit in Primary Care of all patients newly diagnosed with cancer.

Many GPs are already undertaking 'significant event reviews' for each new patient diagnosed with cancer. This includes looking at:

- how many visits were made to primary care with relevant symptoms before referral to hospital (delay pattern analysis)
- the interval from first attendance to referral or definitive diagnostic test

- clinical practice against criteria for referral and prioritisation (NICE Referral guidelines for suspected cancer, 2005).

Community pharmacists and dentists can also play an important role in detecting signs and symptoms early.

There are plans to establish a national audit of cancer diagnosis in primary care. Three pieces of work are being taken forward in 2009, and these are described below.

### 4.2.1 A baseline assessment of interval from first presentation to diagnosis

There are limited data available on the interval from symptom onset to diagnosis for most cancers. Time during this period can be attributed to patient, doctor or system delay. The national audit will examine factors affecting the patient journey from the time of first presentation to the point at which the diagnosis is made, i.e. it will focus on doctor and system delay.

### 4.2.2 An analysis of significant event audits for cancer diagnoses

Significant Event Audit is a quality improvement tool that is in routine use in general practice. Its use is encouraged by the Quality and Outcomes Framework, through that payments are made to general practices

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that undertake 'a minimum of 12 significant event reviews in the past 3 years, which include...two new cancer diagnoses'.

The aim will be to gain insights into the events surrounding the diagnostic process for two specific cancers: lung cancer and cancers in teenagers.

#### 4.2.3 Development of an audit template

Audits of cancer diagnosis have already been undertaken in some parts of the UK, notably in Scotland. Their focus has been largely on the use of the rapid referral process. National audits are in place for some cancer sites (bowel, head and neck, upper gastro-intestinal) but these largely concentrate on the post-diagnosis experience. The aim will be to develop a prototype audit tool for utilisation in 2008/09 and to develop and test a detailed audit tool for general use from 2009/10 onwards, taking account of the findings of the Database study and Significant Event Audit analysis.

The project will be supported by an advisory group drawn together from academic, and service, general practice and the National Awareness and Early Diagnosis Initiative, in association with the Royal College of General Practitioners.

#### 4.3 Cancer screening

The NHS Cervical Screening Programme saves up to 4,500 lives in England each year, and the NHS Breast Screening Programme is estimated to save about 1,400 lives per year. Both these programmes have been operating now for about 20 years. They have been joined more recently by the NHS Bowel Cancer Screening Programme, which began in 2006. A Prostate Cancer Risk Management programme is also operating, although this is not a full screening programme.

The Cancer Reform Strategy sets a number of challenges for commissioners in all cancer screening programmes. These may involve major changes to the way in which services have been delivered over the past 20 years, but they should result in considerable service improvement and health gain for the population served. This does not mean, however, that traditional tasks are no longer important.

For most of the past 20 years, a major task of the local health authority – now the PCT commissioner – has been to concentrate on coverage and participation rates. The best source of data for any given population is the Cancer Screening Quality Assurance Reference Centre (QARC), which can provide detailed information on the quality of the local service and how it compares

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with others in the Strategic Health Authority (SHA). The local primary care support service (PCSS) can provide practice-based information. National statistics, covering the previous financial year, are published every autumn/winter for cervical screening, and late winter for breast screening. These are available at:

[www.cancerscreening.nhs.uk/cervical/statistics.html](http://www.cancerscreening.nhs.uk/cervical/statistics.html) and [www.cancerscreening.nhs.uk/breastscreen/statistics.html](http://www.cancerscreening.nhs.uk/breastscreen/statistics.html).

Population screening coverage is a PCT responsibility, and good coverage across the patch is essential for a high-quality service. Inequalities may be widened if the response is poor in certain areas. Local data can also be obtained from the primary care support service, which can supply coverage data by GP practice for both breast and cervical screening, on a quarterly or annual basis, together with the number of eligible women in each practice who have never had breast or cervical screening.

#### 4.3.1 Breast cancer screening

##### *Coverage and uptake*

For the Breast Screening Programme, uptake is a measure of response to invitations generated by the programme, while coverage measures the proportion actually screened, and includes timeliness of call and recall. Many breast screening services have experienced

slippage in the three-yearly screening round since the last age extension, mainly due to a shortage of radiographic staff. This has reduced coverage, although uptake may remain high when women are eventually invited.

##### *Breast screening and the Cancer Reform Strategy*

The Cancer Reform Strategy increases the workload of the Breast Screening Programme in two ways: first, by adding two extra screening rounds by 2012; and, second, by absorbing family history screening into the programme. This is in addition to the continual demographic pressures of increasing numbers of women in the age group invited. The expansion of the screening programme from seven to nine rounds will be phased in. The exact method of phasing is currently under discussion; however, it is clear that continued additional investment over time, both for breast screening services and also for any resultant treatment services including radiotherapy, will be needed from commissioners in order to achieve and maintain the 36-month interval. The demographic pattern of expansion in the Breast Screening Programme is not expected to go into reverse until approximately 2027.

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### *Digital mammography*

The introduction into the programme of a cohort of younger, pre-menopausal women, a proportion of whom will be at raised risk of breast cancer, introduces new clinical challenges for the programme. Breast cancer is much harder to diagnose or dismiss on the mammogram of such women, due mainly to the increased density of the tissue. Digital mammography has been shown to increase sensitivity in picking up any abnormalities with regard to younger women as well as offering advantages to the service. This includes lower running costs and storage costs over time, as well as improving the productivity and working environment of the radiographers. A further significant advantage of digital mammography is the capability it offers for images to be manipulated and shared. Picture archiving and communications systems (PACS) should ensure that the images are available; furthermore, they can digitally store an unprocessed image to facilitate comparison with any later symptomatic or abnormal screening images. This technological development is likely to require initial increased investment. A central strategy to procure the digital X-ray sets is currently under discussion. At the very least, this would allow local purchasers to take advantage of some bulk-buying discounts.

Many screening programmes are working within boundaries first defined at the outset of the programme, when only analogue equipment was available for imaging and there were only five screening rounds for women of average risk. This is an opportunity for commissioners to look at the infrastructure of the screening programme as a whole, to consider where suitable imaging services might have spare capacity that could be available for screening (provided screening Quality Assurance was applied), and to think about where static screening might be a possibility (since across the country there are increasing problems in finding places to locate mobile units). This would possibly also have the effect of bringing high-quality screening closer to women, improving the service locally and allowing family-history clinics to continue in their current locations. Finally, it should be pointed out that some of the largest breast screening units are so large that they are becoming unmanageable and are having considerable difficulty in meeting the 36-month screening interval and in responding to local needs.

### *Tackling inequalities in breast screening*

A number of inequality issues apply to breast screening. Women aged over the invitation upper-age (currently 70, but rising to 73 by 2012) largely

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consider that they are no longer at risk, whereas in fact the opposite is true. Commissioners may wish to consider improving the communication of the benefits of screening to women locally, together with mechanisms for increasing access (e.g. publicising the fact that women do not need to see their GP to request screening). It is also known that older women often delay presentation of breast cancer, and an

improved awareness of the increased risk could cover both attendances at screening and early presentation of symptoms. Women from minority ethnic groups are also known to participate in screening at lower rates, as are women from the more deprived social groups. Local strategies should be developed to address these inequalities, according to the needs of the local population.

Key commissioning questions for breast screening	Where to find the answers
<b>Coverage/uptake</b>	
What is the uptake of breast screening at first call (prevalent screen)?	Breast screening unit or Quality Assurance Reference Centre (QARC)
What is the uptake for subsequent routine invitations? (1) In previous attenders (incident screens)?  (2) In previous non-attenders?	Breast screening unit or QARC (1) This should be very high (~90%), as previously screened women continue to attend (2) Likely to be only about 21% of those invited, indicating persistent inequalities
What is the coverage for breast screening in your PCT? (Overall figure influenced by programme slippage)  By GP practice? (Poor response in some practices indicates lack of practice support)	Breast Screening Programme statistics for 2005/06 from National Statistics/NHS Information Centre for whole PCT. 2006/07 data due by March 2008.  Primary care support service or QARC

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Key commissioning questions for breast screening	Where to find the answers
What is the current screening round length?	Breast screening unit or QARC (Target 36 months)
<b>Waits</b>	
What is the time from screening to normal results?	Breast screening unit or QARC (Target 2 weeks)
What is the time from screening to assessment?	Breast screening unit or QARC (Target 3 weeks)
<b>Outputs/outcomes</b>	
What proportion of women is referred for assessment: (1) After their initial screen? (2) After subsequent (incident) screens?	Breast screening unit or QARC
What proportions of screen-detected cancers are: (1) Small invasive cancers <15mm (2) Ductal carcinoma in situ (DCIS)	Breast screening unit or QARC
If the breast screening centre is not at your local hospital, what proportion of screen-detected breast cancers is treated by your local MDT?	Breast screening unit, local symptomatic service or QARC
What proportion of women over 70 is requesting breast screening?	Breast screening unit

### 4.3.2 Cervical cancer screening

#### Coverage

Coverage of cervical screening has fallen nationally in recent years, particularly among younger women. The Quality and Outcomes Framework provides a perverse incentive for GPs not to encourage harder-to-reach women to attend, since they are allowed to discount persistent non-attenders. Commissioners should pay particular attention to increasing coverage among women aged 25–35, which has been falling for the past 10 years. These women may particularly appreciate convenient and out-of-hours services, together with high-quality and speedy communication materials.

#### Two-week turnaround of results

The Cancer Reform Strategy requires a two-week turnaround of cervical screening results by 2010. This is not just a cytology laboratory responsibility; rather, it requires a review of the entire screening pathway and all of the organisations involved, from primary care practices to the laboratories and colposcopy clinics in the trusts, and eventually to the primary care support agencies (which send out the results). Cross-border communication may still involve manual inputting of data. In order to increase efficiency and ensure sustainability, both laboratories and PCSS offices may have to merge to cover larger populations.

The Department of Health and the NHS Cervical Screening Programme has published NHS Cervical Screening Programme: Achieving a 14 day turnaround time for results by 2010 (2008), which will assist commissioners in reviewing their local services.

In particular, commissioners should consider:

- better use of information technology
- more advanced biomedical scientist practitioners in cervical cytology
- posting results letters by first class mail
- reconfiguring laboratories to make them larger and more efficient
- using larger call/recall offices to reduce variation in local practices, cut turnaround times and allow better facilities, such as telephone helplines, with out-of-hours and translation services to assist the efforts to improve coverage.

#### HPV vaccination and the cervical cancer screening programme

Human Papilloma Virus (HPV) vaccination for girls aged 12–13 (school year 8) was introduced in September 2008. This is not expected to have an impact on the screening programme for a decade or more, but commissioners may wish to review the messages about HPV and cervical cancer, bearing in mind that the girls' mothers will be in the eligible age range for cervical screening. HPV testing is not yet widespread in the

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programme. A number of sentinel sites are beginning work to test the feasibility of a national protocol for such testing. Consistent messages are particularly important in these areas. However, when considering any local reconfiguration of laboratories, all areas should bear in mind that HPV triage for low-grade abnormalities is likely to be introduced in the near future.

A further issue to be considered during any discussion of the structure of local services is that automation of cytology reporting is currently the subject of a NICE Health Technology Assessment trial. This trial will report in 2010 and, again, if automation is introduced, this will have an impact on the local cytology services and should be borne in mind when any restructuring is considered.

Key commissioning questions for cervical screening	Where to find the answers
<b>Coverage/uptake</b>	
What is the coverage of cervical screening of the target age group (25–64) in your PCT? (<3.5 years and <5 years since last adequate test)	Cervical Screening Programme statistics for 2006/07 from National Statistics/NHS Information Centre for whole PCT
What is the coverage of cervical screening in women aged 25 to 35 in your PCT?	Primary care support service or QARC
What is the coverage of cervical screening in your PCT, by GP practice?	Primary care support service
What is the proportion of women aged 25 to 64 who have never been screened in your PCT, by GP practice?	Primary care support service

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Key commissioning questions for cervical screening	Where to find the answers
<b>Waits</b>	
What is the current turnaround time from taking of the cytology sample to the woman receiving her results?	Primary care support service or QARC
What are the current waiting times for colposcopy clinics? (1) Suspected invasive cancer or suspected glandular neoplasia? (2) High-grade abnormalities (moderate/severe dyskaryosis)? (3) Low-grade abnormalities (borderline or mild dyskaryosis – most unlikely to be cancer but warrants referral to check)?	Colposcopy clinic or QARC (Suspected invasive cancers and suspected glandular neoplasia should already be fast-tracked and seen within two weeks, and high-grade abnormalities within one month)
<b>Outputs/outcomes</b>	
What proportion of women has: (1) Inadequate results? (2) Abnormal results requiring referral to colposcopy?	Primary care support service or QARC
What proportion of invasive cervical cancers is diagnosed in women who have been screened in the last five years? How many have negative results?	Invasive cancer audit data from QARC



### 4.3.3 Bowel cancer screening

The Bowel Cancer Screening Programme is now being rolled out across the country, but it will be two years after screening begins in any given area before coverage data become meaningful. In the meantime, Connecting for Health is developing software that will enable PCTs to monitor uptake as well as performance of their screening centres against the key quality standards, which are available at: [www.bcsp.nhs.uk](http://www.bcsp.nhs.uk).

A national quality assurance programme for bowel cancer screening will begin in 2008/09, with the development of SHA QARCs.

Bowel cancer screening will be fully rolled out by December

2009, by which time all PCTs will be participating (most PCTs are already involved to some extent). From April 2010, the programme will be extended by up to 50%, as the age range invited for screening increases to take in the 75th birthday, rather than the 70th as now. Once again, commissioners should examine capacity, although, as this extension has already been announced, many areas have already been able to plan for it in the design of their services. The extension will be phased in gradually, but will be taking place at the same time as the build-up of surveillance colonoscopies in the programme. Early implementation of this policy took place from September 2008 in five locations to further inform the wider NHS in due course.

Key commissioning questions for bowel cancer screening	Where to find the answers
<b>Coverage/uptake</b>	
What is the uptake for bowel screening in the invited population in your PCT?	Bowel screening centre or programme hub
<b>Waits</b>	
What proportion of those requiring referral: (1) Is seen at an assessment clinic within two weeks of the faecal occult blood test (FOBT) result? (2) Has their colonoscopy within four weeks of the FOBT result?	Bowel screening centre
<b>Outputs/outcomes</b>	
Do >85% accept colonoscopy after a positive FOBT?	Bowel screening centre
Do all screening colonoscopists meet national standards for workload and performance?	Bowel screening centre

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Key commissioning questions for bowel cancer screening	Where to find the answers
What are the detection rates for: (1) Cancer? (2) Adenomas?	Bowel screening centre
What proportion of bowel cancers <b>in the population invited for screening</b> is screen-detected?	Colorectal MDT data
If the bowel screening programme has not yet started in your PCT: (1) What are the waiting times for endoscopy? (2) Has your proposed bowel screening centre been Joint Advisory Group-accredited? (3) Have at least two colonoscopists been accredited for bowel screening? (4) When is the proposed start date for screening?	Local bowel screening steering group/proposed host trust for bowel screening centre/SHA bowel screening lead

#### 4.4 Best-practice guidance on commissioning all screening programmes

Best practice guidance, Collaborative commissioning of National Screening Programmes, was published by the Department of Health in 2007. This identified call/recall and laboratory services in cervical screening, and the programme hubs for bowel cancer screening, as being suitable services to be commissioned by specialist commissioning groups. It was, however, considered that colonoscopy in cervical screening, endoscopy in bowel cancer screening and the breast screening units could all be better procured at a local level. National

tariffs do not yet exist for any of these activities, with the exception of colonoscopy, although the national office of the cancer screening programmes is working towards the development of agreed currencies for the remaining activities. Commissioners should endeavour to move away from block contracts to an activity-based approach, reflecting the number of people appropriately screened. Commissioners may find that the cancer screening website contains helpful information about the three cancer screening programmes and the Prostate Cancer Risk Management programme.

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#### 4.5 Prostate Cancer Risk Management programme

There is no national prostate cancer screening programme, but suitably informed individual men may be tested through the Prostate Cancer Risk Management programme. Nevertheless, commissioners should ensure that local GPs are aware of, and are utilising, the information provided by the Prostate Cancer Risk Management programme, which was re-launched in late summer 2008. They should also ensure that those local laboratories providing testing for the local population are using tests that conform to national standards and are applying the nationally recommended, evidence-based, age-related referral guidance. When the pack is relaunched, this will align prostate specific antigen (PSA) testing with the NICE guidance on improving outcomes in prostate cancer.

The Cancer Commissioning Toolkit contains the following related metrics. These can be found by accessing the corresponding chapter **Awareness, Screening and Early Detection** and the sections **Screening** and **Referrals**, either via the dashboard or the contents page.

##### Screening

- screening coverage
- screening coverage, time trend.

##### Referrals

- TWR performance
- TWR performance, time trend
- Percentage of TWR with cancer diagnosis
- Number of TWR with cancer diagnosis.

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## 5. Assessment, Diagnosis and Staging

This chapter will be added to the guidance at a later date.

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## 6. Commissioning improved treatment services

### 6.1 Meeting waiting times

#### 6.1.1 Key issues/background

The NHS Cancer Plan included a number of cancer waiting times standards that the NHS was expected to achieve, including:

- two week standard from urgent GP referral for suspected cancer to first hospital assessment (by 2005)
- 31 day standard from diagnosis/decision to treat to first treatment (by 2005)
- 62 day standard from urgent GP referral for suspected cancer to first treatment (by 2005)
- 31 day standard from urgent GP referral for suspected cancer to first definitive treatment for children's cancers, testicular cancers and acute leukaemia (by 2001).

Excellent progress had been made on all of these cancer waiting times standards as a result of concerted effort and co-ordination across primary and secondary care. These standards do not, however, apply to all cancer patients. Chapter 4 ('Ensuring better treatment') of the

Cancer Reform Strategy therefore confirmed that the current standards would be expanded to extend the range of patients that could benefit. As a result of this:

- the existing two week standard has been expanded so that any patient referred with breast symptoms will be seen within two weeks whether cancer is suspected or not – this standard is to be delivered by December 2009
- the existing 31 day standard has been expanded to cover subsequent treatments for all cancer patients including those diagnosed with a recurrence – this standard is to be delivered by December 2008 where drug treatment or surgery is a subsequent treatment and by December 2010 where radiotherapy or other treatments are a subsequent treatment
- there are now two additional entry points for the 62 day standard, where cancer is suspected:
  - Referral from NHS Cancer Screening Programmes (breast, cervical and bowel) – this extended standard is to be delivered by December 2008
  - a consultant's decision to upgrade the urgency of a patient, e.g. following a non-urgent referral – this extended standard is also to be delivered by December 2008.

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Organisations should already be considering how to put in place the processes needed to deliver these new extended standards within the required timeframes.

This chapter of the Cancer Commissioning Guidance focuses on embedding change in care pathways for both the existing and expanded standards.

### 6.1.2 Performance indicators

#### *Ready reckoner*

Data on all patients whose care is covered by the cancer waiting times standards need to be uploaded onto the Cancer Waiting Times Database (CWT). As a measure of data completeness, all organisations are expected to report data on 80% of their expected cancer incidence for the existing cancer waiting times standards. This is known locally as the 'ready reckoner', and is based on both incidence data provided by the Cancer Registries and expected throughput of cancer patients in the organisation. The intention is to issue a ready reckoner for the expanded targets once Information Standards Board (ISB) approval is secured for the supporting dataset.

#### *Operational standard*

The aim is to ensure that as many patients as possible are seen and treated within the timescales set by the cancer waiting times standards. However, for a small number of cancer patients, there are good clinical

reasons for their care pathway not to be completed within cancer waiting times standards. Reasons for this vary according to individual patients and the type of cancer. For example, an inconclusive trans-rectal ultrasound biopsy for suspected prostate cancer will be repeated, but there will need to be a time delay before the patient can be retested to allow the patient to recover. These reasons are known as 'clinical exceptions' and they mean that it is not possible (or expected) for cancer waiting times standards to be achieved for 100% of cancer patients.

For the existing cancer waiting times standards operational standards were therefore set by the Healthcare Commission to take into account the likely proportion of clinical exceptions that would be associated with each standard. The operational standards were set at:

- 98% for the two week urgent GP referral to first hospital assessment standard (i.e. a threshold of 2% to allow for clinical exceptions)
- 98% for the 31 day from decision to treat to first definitive treatment standard (i.e. a threshold of 2% to allow for clinical exceptions)
- 95% for the 62 day from urgent GP referral to first definitive treatment standard (i.e. a threshold of 5% to allow for clinical exceptions).

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Patients who are such clinical exceptions continue to be recorded on the cancer waits database even though they breach the waiting times standards. All providers of cancer services are expected to achieve these predetermined operational standards.

#### *Proposed changes to operational standards*

Adjustments are when a trust can effectively 'stop the clock' for a given period to take into account medical or social reasons that make progress along the pathway impossible. The three points along the cancer care pathway where such adjustments have been possible are:

- outpatient waits
- diagnostic waits
- treatment waits.

Adjustments at each of these three points have been allowed to take account of:

- did not attend (DNAs)
- patient cancellations
- deferrals of admission
- medical suspensions
- social suspensions
- patient choice.

However, the intention, subject to approval by the ISB, is to move to the 18-week 'pause' model for the new and existing cancer waiting times standards. The 18 Weeks Rules state:

*'A clock may be paused only where a decision to admit has been made, and the patient has declined at least 2 reasonable appointment offers for admission. The clock is paused for the duration of the time between the earliest reasonable offer and the date from which the patient makes themselves available again for admission...'*

*An 18-week clock stops when it is communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay that:...*

*e) A patient DNAs their first appointment following the initial referral that started their 18 week clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient... DNAs for a first appointment following the initial referral that started an 18-week clock nullify the patient's clock (i.e. it is removed from the numerator and denominator for Referral to Treatment time measurement purposes).'*

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This will mean that:

- no pauses will be possible for medical reasons
- no pauses will be allowed during the diagnostic phase of the 62 day standard (i.e. between first seen and decision to treat)
- no pauses will be allowed for waits for treatment that will take place in an outpatient setting, for example the majority of chemotherapy and radiotherapy.

The only pauses allowed (and therefore where adjustments for these pauses will be allowed to be made) will be:

- *during an outpatient wait* – a pause will be allowed if a patient DNAs their initial outpatient appointment
- *during a wait for **inpatient** treatment* – a pause will be possible where the patient declines admission, providing that the offer of admission was 'reasonable'.

More detailed guidance on the changes to the adjustments for cancer waiting times will be issued once ISB approval has been received for the updated dataset.

The use of operational standards will continue but will need to be revised to take into account the move to the 18-week pause model. In addition the operational standards will need to take into account the average delivery that should reasonably be expected across all tumours and the fact that certain tumours are likely to deliver above this threshold (e.g. breast) and others below (e.g. lung and urology) due to complexities of the cases in these areas. For example, a patient with lung cancer where surgery is an option will require further staging investigations, which may involve additional providers. This needs an integrated approach between organisations to streamline the pathways.

The operational standards for the existing standards and the expanded standards will be developed in collaboration with the Healthcare Commission. These are likely to be set once the first period data are available (probably spring/summer 2009). Although it is not yet known what the new operational standards will be, they will be lower than the existing operational standards and it is expected that the operational standard for the extended 31 day standard will differ for inpatient and outpatient treatments.

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Further information on the existing standards is available in *Cancer Waiting Targets: A Guide (Version 5)*, which defines the existing clinical exceptions and outlines when a timed adjustment (removal of days) from a patient's pathway can currently be made. Updated guidance (including the proposed changes to adjustments) will be issued as soon as ISB approval for the planned dataset changes to support the extended cancer waiting times standards is given.

### 6.1.3 Challenges to organisations

The key challenge to organisations in meeting the existing standards has been to identify and develop robust and effective clinical and information pathways for all patients covered by these standards to ensure that they are treated within the cancer waiting times operational standards.

In many networks, this has required, and in some places still requires, redesign both within and between organisations and across the pathway of care to ensure that these standards can be delivered in a sustainable way.

For the existing standards, providers fall into one of three categories:

- those delivering the standards through robust, effective clinical and information pathways
- those achieving the standards through short-term, unsustainable methods (which can be costly to commissioners if waiting list initiatives are repeatedly used to clear waiting list backlogs where there is a capacity/demand imbalance)
- those struggling to achieve the standards, e.g. because they lack effective pathways.

Commissioners need to ensure that robust arrangements are in place, with:

- redesigned pathways, where appropriate incorporating the Cancer High Impact Changes identified by NHS Improvement as being of benefit to patients
- robust information on where patients are in the pathway
- proactive pathway management, with patients steered through the system, within and across organisations.

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In addition commissioners need to be able to performance manage organisations against the standards. This might require more detailed analysis of patient-level data if problems are identified in delivering particular standards as a whole or for particular tumour groups. These local 'insights' provide important quality indicators of the local service and enable organisations to monitor or audit all patients against local pathways. As a result, when a breach does occur, it is more apparent whether there is a local service issue that may need to be addressed, or if it has been a one-off departure from normal clinical practice. Examples of useful indicators are included within the commissioning questions in the following section.

For the expanded standards the key challenge to organisations will be to:

- have processes in place to identify and track patients along the new pathways
- ensure that effective pathways are in place – this will require pathway redesign where necessary (e.g. considering how breast clinics are run) and also building up capacity in areas such as radiotherapy
- ensure that local systems are in place to capture data needed to support the revised cancer waiting times dataset (once it is approved by the ISB) so that it is possible to demonstrate that the standards are being achieved

- ensure that prospective patient management and navigation systems are in place – implementation of a Priority Target List (PTL) should support this (carried out on a voluntary basis until such time as PTL is mandated by the Department of Health).

Achieving and sustaining both the existing and expanded cancer waiting times standards requires time, determination, focus and combined organisational effort, with strong clinical and managerial leadership. Further information on achieving and sustaining cancer waiting times can be found in the 'How to' guide and other supporting publications.

#### 6.1.4 Commissioning questions

The key questions that commissioners should ask to assure themselves that they are commissioning appropriate clinical pathways, delivered in a timely manner and based on the cancer waits information, are:

*Existing standards*

1. Are organisations regularly achieving the operational standards for all three cancer waiting times targets (two week referral, 31 and 62 day)?

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- if the answer is no, then organisations need to provide evidence of what they are doing to rectify the situation within an acceptable time.

For example:

- use of a PTL to prospectively track patients on these pathways and identify those that need to be prioritised for diagnostic tests, staging or treatment dates
- development of timed pathways (agreed by the local Cancer Network Tumour Site Specific Groups) – see: [www.cancerimprovement.nhs.uk/View.aspx?page=/how\\_to\\_guide.html](http://www.cancerimprovement.nhs.uk/View.aspx?page=/how_to_guide.html).

## 2. What percentage of all cancer patients is referred via the two week referral process?

- the current national average is about 40% of all cancer cases. The percentage will differ by tumour but is an indicator of how many patients are coming through this route and whether more can be done to educate the public and GPs about the signs and symptoms of cancer
- if an organisation is significantly above or below this level, then questions should be asked about both the number and the appropriateness of two week referrals being made to secondary care by primary care, since this might indicate that too many inappropriate or too few appropriate referrals are being made

- organisations could be asked to provide evidence on all referral routes into their organisation, especially if there are other locally agreed services in operation to fast-track patients into their services, e.g. straight to test processes.

## 3. What percentage of two week referrals is received by the provider organisations after 24 hours?\*

- the current national average is around 4.7%
- if this is higher than the national average then this is a potential bottleneck in the patient pathway. Questions should be asked of GP practices regarding their referral processes into secondary care, and what processes are in place to ensure that referrals are received by secondary care within 24 hours.

## 4. What percentage of all two week referrals is diagnosed with cancer – for all cases, and by different cancer type?

- the current England average is 13% although the percentage will differ by tumour – it gives an indication of the volume/accuracy/appropriateness of referrals from primary care

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- if the benchmarked data show the Primary Care Trust (PCT)/network/organisations fall within the bottom quartile (fewer patients diagnosed with cancer than in other organisations), then questions may need to be asked about the interpretation of the National Institute for Health and Clinical Excellence (NICE) referral guidelines for suspected cancer, i.e. whether many of the patients referred by primary care do not meet the guidelines
- in addition, local teams in secondary care could be asked to audit the appropriateness of all two week referrals received and to provide a quarterly report on their findings.

### 5. What is the median time period (days) between the two week referral and date of decision to treat for different cancer types?

- the time period between referral and the agreement of a treatment plan gives an indication of any potential bottlenecks in the diagnostic phase of the pathway.\*

### 6. What percentage of 62 day patients within the cancer network is 'seen and treated' within more than one organisation (known as an inter-trust transfer) and is treated within the 62 day target period, and is this increasing over time?

- this is an indicator of patients whose pathways are managed by multiple providers and if/how that might impact on the speed with which their diagnosis is achieved and treatment delivered
- if the performance for this metric is substantially below 95%, all organisations should demonstrate their commitment to unified, robust pathways across organisations, and provide, on a quarterly basis, a breach analysis to demonstrate where the delays in service are
- in addition, the cancer network and all local organisations should provide evidence of local communication and information-sharing protocols, with evidence that there is synergy with the clinically effective pathway
- it is often viewed as good practice to refer a patient to the organisation that will be carrying out the first definitive treatment by day 42 of the pathway to enable the 62 day pathway to be met – policies to facilitate this and/or analyses to see how referrals compare with this informal standard may be of use.

Information associated with the above questions is benchmarked within the Cancer Commissioning Toolkit, with the exception of those items marked \*.

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*Expanded standards*

7. Commissioners will want to assure themselves that cancer networks and their constituent organisations have plans and processes in place to deliver the new 'Going Further on Cancer Waits' standards within the necessary deadlines and will want to know the likely impact on performance against the existing cancer waiting times measures.

8. Through contract monitoring, commissioners should ask providers to assess the impact of Going Further on Cancer Waits to assure themselves that there are realistic action plans in place to achieve this and that delivery of the existing standards will be sustained.

9. Overarching questions commissioners should ask include:

- a Do you commission effective, timed tumour or symptom-specific pathways for all patients with suspected or confirmed cancer within and across organisations?
- b Do you have robust, specific patient information and administrative systems, which support effective pathway management?
- c How confident are you that the organisations you commission services from can deliver and then

sustain delivery of the Going Further on Cancer Waits standards?

- d Is your organisation making effective use of cancer network service improvement resources to support delivery of the Going Further on Cancer Waits standards?
- e Is your cancer network effective in supporting sustainable delivery of the Going Further on Cancer Waits standards?

10. In addition, commissioners should ensure that the following actions take place to support and sustain delivery. They should:

- a Develop and implement a strategic framework for cancer waits delivery in conjunction with the Strategic Health Authority (SHA).
- b Nominate an executive PCT cancer lead and ensure active and senior membership of the Cancer Network Board.
- c Commission effective redesigned tumour or symptom-specific pathways for all patients with suspected or diagnosed cancer within and across organisational boundaries which are incorporated into the PCT quality specifications with trusts (additional information and guidance on commissioning can be obtained through the Cancer Commissioning Toolkit).

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- d Use local service improvement teams to support pathway redesign within primary care and across the primary/secondary care interface.
- e Agree referral guidance and audit compliance, ensuring that systems and processes are developed to include a feedback loop to primary care.
- f Ensure that there is adequate diagnostic capacity and provision to meet the waiting times standards.
- g Implement robust and effective information systems that provide good information for management decisions, as alluded to in the national contract for acute services.
- h Monitor network effectiveness in supporting delivery.
- i Contribute effectively to the network's work programme including supporting network-wide pathways and inter-trust transfer processes.
- j Ensure that networks are fit for purpose and are held to account for delivering agreed objectives through formal review.

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## 6.2 Tumour key questions – high-quality surgical and other services in line with improving outcomes guidance

Comprehensive service guidance for cancer has been published by the Department of Health and (since 2002) by NICE. Some of this guidance requires the reconfiguration of surgical oncology; all of it requires a team approach to patient care. The guidance is mandated by the NHS Cancer Plan and reinforced by the Cancer Reform Strategy. Implementation of the guidance is audited through the cancer peer review process, the reports of which are published.

The principle behind reconfiguring specialist surgical oncology is founded on two tenets. First, there is a solid evidence base of a positive relationship between volume

(of surgery performed) and outcome; second, the need for specialists to be assembled into teams in order to offer a sustainable and continuous specialist service. The consequence is that specialist cancer surgery should only be performed by specialists working in teams that are located in approved hospitals serving a particular population size.

There are a number of generic metrics that apply to all cancer multidisciplinary teams, and these are listed below, together with the source of the data. Some of these metrics are not pertinent to all tumour sites – e.g. for breast and colon cancers, it is less relevant to look at inter-hospital breaches, as this surgery does not usually require referral to a specialist centre. In addition, each of the tumour sites has tumour-specific issues to address, and these are identified in the individual tumour sections.

### 6.2.1 Cancer multidisciplinary teams (MDTs)

Generic key commissioning questions for Cancer MDTs	Where to find the answers
<b>Team working</b>	
Does each specialist team dealing with a particular type of cancer have the relevant core membership?	Cancer Quality Improvement Network System (CQuINS)
How good is attendance at MDT meetings for each team? (Should be at least two-thirds.) How good is cover for team members?	CQuINS

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Generic key commissioning questions for Cancer MDTs	Where to find the answers
What is the overall level of compliance with peer review measures for each team dealing with a particular type of cancer?	CQuINS
How many new cancers does each team deal with in a year?	Cancer Waiting Times Database (CWT)
What proportion of new cancer patients is discussed at MDT meetings?	Local audit
<b>Waiting times/access</b>	
What proportion of new cancers is referred through the urgent (2WW) route (and non-urgent route) and how does this compare with national figures?	CWT
What proportion of 2WW referrals has cancer?	CWT
Are the 31/62 day targets met for a particular type of cancer?	CWT
Are there inter-hospital transfer breaches?	CWT
Is there streamlined access to assessment for co-morbidities?	Local information



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Generic key commissioning questions for Cancer MDTs	Where to find the answers
<b>Treatment</b>	
What percentage of patients is entered into clinical trials?	Local information
<b>Length of hospital stay</b>	
What is the average length of stay for a particular type of cancer?	Hospital Episode Statistics (HES)
What is the average length of stay for a particular procedure?	HES
What are the pre/post-operative bed days?	HES
How many/what proportion of cases are readmitted owing to complications during a year?	HES
<b>Incidence/mortality/survival</b>	
What is the incidence of a particular type of cancer in this locality?	Cancer Information Service (CIS)
Is the age standardised mortality rate for a particular type of cancer falling in line with England/Europe?	CIS
What is the 30 day mortality rate following surgery in this unit (e.g. relevant to oesophagus, gastric, pancreatic and lung cancer)?	Link to HES/registry

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<b>Generic key commissioning questions for Cancer MDTs</b>	<b>Where to find the answers</b>
What is the hospital mortality after resection?	HES
What are the one-, two- and five-year survival rates?	CIS
What proportion of all deaths are in hospital?	HES/Office for National Statistics (ONS)
<b>Audit</b>	
Is staging and co-morbidity data collected on all new patients with cancer?	Local information
Does the unit participate in national audits?	National Clinical Audit Support Programme (NCASP)/ Breast Cancer Clinical Outcome Measures (BCCOM)
What proportion of cases is reported and with what level of data completeness for treatment and care-mix fields?	NCASP/BCCOM/local provider
Does the MDT/Network Site Specific Group collect (for the whole team and for individual surgeons) audit information on the number of operations performed and serious operative complications? Does the team have a process for review of complications?	Local information
<b>Quality of patient experience</b>	
Percentage compliance with patient experience measures	CQuINS

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### 6.2.2 Breast cancer

Breast cancer surgeons should, for small lesions, offer the choice of mastectomy or breast conserving surgery (BCS), the latter normally with adjuvant radiotherapy. BCS should increasingly be offered on a short-stay (day case) basis, and is facilitated by using sentinel node biopsy to identify the minority of cases that require more extensive surgery to remove lymph nodes.

With regard to breast cancer choice and efficiency, women with small single tumours should be offered the

choice of mastectomy, immediate breast reconstruction, or BCS with adjuvant non-surgical treatment if indicated. Minimally invasive surgery with early rehabilitation is desirable where possible.

The following are suggested breast cancer specific issues that could be addressed by commissioners in addition to the generic key commissioning questions, when looking for a high-quality service:

Key commissioning questions for breast cancer	Where to find the answers
<b>Team working</b>	
Does the specialist breast team treating your patients manage at least 100 diagnoses a year?	HES/local audit
Does each surgeon manage at least 50 new cases a year?	HES/local audit
<b>Waiting times/access</b>	
What proportion of newly diagnosed cases is not referred through screening or the two week referral route? (Should be less than 30% and aim for no more than 10%.) (Note that this will change with new target.)	Screening/CWT/local provider
<b>Treatment</b>	
What is the ratio of mastectomy to BCS (the national average is close to 1:1)?	HES

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Key commissioning questions for breast cancer	Where to find the answers
What proportion of women receiving surgery for breast cancer has a sentinel node biopsy?	Local provider
What proportion of women receiving surgery for breast cancer has an axillary node clearance?	HES
What proportion of women receives immediate breast reconstruction?	HES
What proportion of women undergoing resectional surgery and receiving adjuvant or neo-adjuvant chemotherapy is tested for HER2 prior to commencement of drug treatment?	Local provider
<b>Length of hospital stay</b>	
What is the average length of stay for breast cancer with any surgical procedure? (This will provide an overall average, including reconstruction.)	HES
What proportion of women undergoing BCS is treated as day cases or has a length of stay of two days or less? (This should become the norm.)	HES
What is the average length of stay for breast conserving surgery?	HES
<b>Audit</b>	
Does the team submit data to the BCCOM dataset (managed by the West Midlands Cancer Intelligence Unit)?	BCCOM

### 6.2.3 Lung cancer

Lung cancer remains an area of concern, since the overall survival rate has improved little over the past decade and there continue to be large variations in practice around the country. In particular, resection rates aimed at cure vary from less than 5% to around 20%, and access to chemotherapy and Continuous Hyperfractionated Accelerated Radio Therapy (CHART) is also highly variable.

The proportion of patients for whom the diagnosis is confirmed by histology or cytology is well over 80% in some centres and nearer 50% in others. This histological confirmation rate is probably a good surrogate marker of the overall standard of a lung cancer service, and is more easily measured than many other indicators.

Although the five-year survival rate remains very low (6–8% in this country compared with 15–17% in some other European countries), good-quality survival can be extended with appropriate treatment, including chemotherapy, radiotherapy and possibly photodynamic therapy. Longer-term survival is normally achieved with surgery, radical radiotherapy or combination chemo-radiation in patients with non-small cell lung cancer (NSCLC). Virtually all patients with NSCLC in whom

surgery, radical radiotherapy or combination chemo-radiation is planned should be staged with Positron Emission Tomography/Computerised (Axial) Tomography (PET/CT) prior to treatment.

The less common small cell lung cancers (SCLC) generally respond well to chemotherapy, but five-year survival is only around 2%, and most such patients are not suitable for surgical resection. However, even with this highly chemo-sensitive tumour, only 58% of patients nationally receive chemotherapy, with rates varying from under 50% to over 80%.

The National Lung Cancer Audit (LUCADA) is now well established and is the source of many of the data quoted above. Data completeness and participation, however, are still limited in some areas.

The following are lung cancer specific suggested issues that could be addressed by commissioners, in addition to the generic key questions, when looking for a high-quality service.

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Key commissioning questions for lung cancer	Where to find the answers
<b>Prevention</b>	
Is a smoking-cessation programme in place locally?	PCT
<b>Treatment</b>	
In what proportion of patients managed by the MDT is the diagnosis confirmed by histology or cytology?	Cancer Registry
What is the curative surgical resection rate for patients with NSCLC?	HES/Cancer Registry
What proportion of patients with NSCLC receives any form of active anti-cancer treatment (including surgery, chemotherapy and radiotherapy)?	Local provider/National Lung Cancer Audit (LUCADA)
What proportion of patients with SCLC receives chemotherapy?	Local provider/LUCADA

### 6.2.4 Colorectal cancer

Approximately 75–80% of patients presenting symptomatically with colorectal cancer will have a surgical resection aimed at cure. There have been improvements in the surgical management of rectal cancer in terms of outcome, as well as a reduction in the abdomino-perineal resection rate with permanent colostomy. Shorter lengths of stay and improved patient experience can be achieved by performing the surgery laparoscopically and/or by early mobilisation and rehabilitation regimes, either of which should result in discharge after about four days post-surgery.

There has also been a large increase in the number of patients with liver metastases undergoing resection of the affected part of the liver – a procedure with reported five-year survival rates of as high as 45%. However, again there are large variations in practice.

Approximately 20% of patients with colon cancer present as surgical emergencies – mostly with obstruction, some with perforation. These patients generally have poorer outcomes, and it is therefore more important that specialists should treat them. Paradoxically, this is less likely to happen. Recent

guidance has suggested new approaches to the management of emergencies, so that patients are transferred to specialist teams before surgery, especially in the case of obstruction. Emergency presentations with rectal cancer are less common and are usually due to haemorrhage. Such cases should only be operated on by designated rectal cancer surgeons.

Colorectal cancer is a common disease, which classically benefits from multi-modality treatment. Many patients with rectal cancer, for example, would receive pre-operative radiotherapy, surgery from designated and specially trained surgeons and then chemotherapy (depending on the anatomical stage of disease). Developments in the quality of care and rehabilitation are altering patients' experience and outcomes significantly. It is consequently of major importance that the teams treating these patients have sufficient workload and experience to sustain their expertise.

The following are suggested colorectal cancer specific issues that could be addressed by commissioners, in addition to the generic key questions, when looking for a high-quality service.

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Key commissioning questions for colorectal cancer	Where to find the answers
<b>Team working</b>	
Does the team treating your patients manage at least 60 new patients each year?	HES
Does each surgeon managing colorectal cancer (excluding emergencies) perform at least 20 curative resections each year?	HES
Is there expertise within the team to offer minimally invasive (laparoscopic) bowel surgery to patients?	
<b>Access</b>	
What proportion of patients with rectal cancer who are undergoing curative surgery receives pre- or post-operative radiotherapy?	Local provider
<b>Treatment</b>	
What proportion of rectal cancer procedures are abdomino-perineal resections? (Abdomino-perineal resection to anterior resection rates vary from 3 to 30%, and a norm of 10 to 15% should be expected.)	HES
In what proportion of patients undergoing curative surgery is there leakage at the anastomosis?	Local provider
In what proportion of patients undergoing curative resection is the circumferential resection margin free of tumour?	Local provider



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Key commissioning questions for colorectal cancer	Where to find the answers
What proportion of patients with a diagnosis of colorectal cancer has undergone surgery for the resection of liver metastases? (There is no standard rate but a population-based rate of 50–75 per million is achieved in the best centres.)	HES/local provider
How many procedures are undertaken laparoscopically? Does the hospital have an enhanced recovery programme in place?	Local provider/HES
<b>Length of hospital stay</b>	
What is the average length of stay for patients with colorectal cancer with a surgical procedure? (Should be less than seven days, with a median of four days post-operation.)	HES
<b>Audit</b>	
Does the unit (MDT, centre, network) managing your patients submit data to the National Bowel Cancer Audit (NBOCAP)? (Current data suggest that only about 40% participate.)	National Bowel Cancer Audit (NBOCAP)/local provider

### 6.2.5 Gynaecological cancers

The Improving Outcomes in Gynaecological Cancers guidance was published in 1999 and led to the centralising of treatment planning and most of the cancer surgery at a network level (with an assumption of 800,000 to 1 million population, this allows up to two specialist teams in the largest networks). The implementation of this guidance should now be complete. There is, however, some evidence that local teams are continuing to operate on a wider range of cancers than is approved in the guidance. Locally delivered surgery – which must first be approved by a specialist team – should be restricted to very early stage cancers of the uterus, and should amount to no more than 15–20% of the total of gynaecological cancer resections.

The guidance covers cancers of the body of the uterus (endometrium), the uterine neck (cervix) and ovary, and rarer cancers of the vulva and vagina. When children's and young people's services have been reconfigured (by December 2010), germ cell tumours should normally be managed by specialist gynaecology teams linked to the children's and young people's services.

Ovarian cancer is a difficult disease to treat and has a rather poor prognosis. Exemplary surgery and active non-surgical management should be expected.

The following are suggested issues that could be addressed by commissioners when looking for a high-quality service.

Key commissioning questions for gynaecological cancers	Where to find the answers
<b>Team working</b>	
What is the percentage of gynaecological oncology surgery performed outside a specialist team centre? (A figure of over 20% suggests that not enough of the surgery has been centralised.)	HES
Is any non-uterine gynaecological cancer surgery performed outside a specialist team centre? (The particular area of concern is ovarian cancer presenting as an emergency or unexpected finding.)	HES

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Key commissioning questions for gynaecological cancers	Where to find the answers
Does every surgeon in the specialist MDT who manages gynaecological cancer spend at least 50% of their direct clinical care time on the management of cancer cases?	Local provider
<b>Treatment</b>	
What is the percentage of ovarian cancer resection performed as an emergency procedure? (Although occasional cases are probably unavoidable, the diagnosis should normally be suspected prior to surgery, and referred to the specialist team for discussion and possible surgery.)	HES

### 6.2.6 Oesophago-gastric cancers

The original Improving Outcomes in Upper Gastro-intestinal Cancers guidance, published in 2001, estimated that a population of 1 million would generate 250 incident cases of oesophago-gastric cancers and 100 radical resections per year. Subsequent improvements in staging and alternative treatments, including stenting and chemotherapy, however, have reduced the number of resections to 60–70 per million. A much higher resection rate would cast doubt on the effectiveness of staging and case selection. Specialist teams in approved specialist centres should perform all oesophago-gastric surgery.

Upper gastro-intestinal (GI) cancers have a poor prognosis. Radical surgery, especially for oesophageal cancer, is disabling and has a significant operative mortality rate which is equivalent to other major surgery such as cardiac surgery, and should not be considered unless there is a chance of cure. All patients should be fully staged with multi-slice Computerised (Axial) Tomography (CT) scanning; those undergoing radical treatment with oesophageal and oesophago-gastric junctional cancers should have an endoscopic ultrasound (EUS). Laparoscopy should be considered for all with oesophago-gastric junctional and gastric cancers and those considered for oesophageal surgery should be further staged with PET/CT.

The following are suggested issues that could be addressed by commissioners when looking for a high-quality service.

Key commissioning questions for oesophago-gastric cancers	Where to find the answers
<b>Team working</b>	
Is any curative resection performed outside a specialist team centre? (There should be none.)	HES
<b>Treatment</b>	
What are the curative resection rates for gastric and oesophageal cancers? (Overall rates should be about 20–25% for oesophageal and gastric cancer.)	HES
What proportion of patients undergo pre-operative chemotherapy? (The expectation would be 75%.)	Local provider
What is the average number of lymph nodes removed at radical surgery? (Should be at least 15 for accurate staging.)	Local provider
<b>Length of hospital stay</b>	
What is the average length of stay for patients with upper GI cancers undergoing radical resection?	HES

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### 6.2.7 Pancreatic cancer

Pancreatic cancer is difficult to treat. Radiotherapy has little place and the benefits of chemotherapy are relatively modest, although adjuvant chemotherapy (with resectional surgery) is now well established and offers similar benefits to those in oesophago-gastric cancer.

Most patients present when the disease is beyond cure. Palliative care is central to managing these patients.

Surgical resection is possible in a minority of cases, but careful staging is required, with three-dimensional imaging, endoscopic ultrasound and stage laparoscopy to avoid fruitless surgery.

The following are suggested issues that could be addressed by commissioners when looking for a high-quality service.

Key commissioning questions for pancreatic cancer	Where to find the answers
<b>Team working</b>	
Are any pancreatic resections performed outside designated specialist pancreatic cancer teams? (There should be none.)	HES
<b>Treatment</b>	
What is the curative resection rate for pancreatic cancer? (A rate above 25% is likely to imply inadequate assessment and staging, but there do appear to be higher rates in some specialist units.)	HES
<b>Length of hospital stay</b>	
What is the average length of stay for patients undergoing radical surgical resection? (Should be around 14 days post-operation.)	HES

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### 6.2.8 Urological cancers

NICE guidance on improving outcomes in urological cancers was published by NICE in 2002. It established several different levels of cancer teams. Local urology teams would still manage most patients with bladder, prostate and renal cancers. Specialist teams serving at least 1 million people would provide specialist surgical and radiotherapy treatments for people with localised prostate cancer who opt for radical treatment, for bladder cancers requiring radical surgery, and for a small number of renal cancers requiring complex surgical techniques. Designated specialist teams must undertake a minimum of 50 radical procedures (cystectomy and/or prostatectomy) at an approved hospital site where surgery is undertaken. Testicular cancer should only be treated by teams serving at least a 2 million catchment population; and penile cancer by teams serving at least 4 million people. Implementation of this guidance should have been completed by the end of 2007.

Prostate cancer is now the most common cancer in men. The recorded incidence has increased rapidly in recent years, owing to increased case ascertainment using blood tests for prostate-specific antigen (PSA) and biopsy. Although more than 10,000 men die of prostate cancer each year, it is not known how many cases are indolent or incidental findings which would not have required active treatment.

Because access to PSA testing varies across the country, there is no consistency about the nature or importance of the disease. Where PSA testing rates are high, five-year survival rates will also tend to be high. However, these areas typically have mortality rates that are close to the national average. Conventional survival data are a poor guide to the quality of treatment services. To add to the uncertainty, men with localised prostate cancer (about 65% of all presenting cases) have several treatment options, whose relative value is uncertain. These include surgery (using open technique or laparoscope, with or without robotic assistance – robotic surgery reducing the length of stay), radiotherapy (conformal external beam or brachytherapy) or a more conservative approach of active surveillance, where treatment is postponed until there is evidence of active disease. The choice is essentially that of the man concerned (with some exceptions covered in the recent NICE clinical guidelines). Radical prostatectomy is a complex operation and is uncommonly offered to men aged over 70 years. Radiotherapy is still the most common radical treatment used in prostate cancer. Some other treatments, such as cryosurgery or high-intensity focused ultrasound (HIFU), are not recommended, except in research settings.

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Radiotherapy regimes vary across the country, with some centres, especially in the North of England, using 20 fractions, whereas the recommended regime involves at least 37 fractions. Also, some areas of the country have restricted access to brachytherapy, which is now the subject of Department of Health guidance.

All radical treatments for prostate cancer can have severe side effects, and the option of avoiding such treatment is preferred by many men. The management of more advanced disease is also contentious. Hormone therapy, using drugs, and orchidectomy are effective in slowing the progression of active disease but are

also accompanied by serious unwanted effects. Chemotherapy is also emerging as a treatment option in the later stages of the disease.

The following are suggested issues that could be addressed by commissioners when looking for a high-quality service.

Key commissioning questions for prostate cancer	Where to find the answers
<b>Team working</b>	
Are any radical prostatectomies performed outside a specialist team centre? (There should be none.)	HES

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Key commissioning questions for prostate cancer	Where to find the answers
<b>Treatment</b>	
What is the number of radical prostatectomies performed for prostate cancer, compared with the number receiving external beam radical radiotherapy, brachytherapy, other surgical treatments (e.g. HIFU, cryosurgery) and active surveillance as the first definitive treatment for early prostate cancer? (Note that CWT records 'active monitoring', which is not quite the same as 'active surveillance'. A reasonably even distribution between surgery, radiotherapy (any type) and active surveillance would be expected.)	Local provider
Is laparoscopic or robotic prostatectomy available?	Local provider
How many fractions are used in your radical radiotherapy regime? (Should be at least 37.)	Local provider
Are conformal delivery and access to brachytherapy available?	Local provider
<b>Length of stay in hospital</b>	
What is the median length of stay for men undergoing radical prostatectomy? (It should be less than seven days.)	HES



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Key commissioning questions for prostate cancer	Where to find the answers
<b>Audit</b>	
Is a clinical audit dataset recorded for prostate surgery? A minimum dataset should be an absolute prerequisite for commissioning. This should include audited records of pre-operative PSA, pathological stage/grade, pre- and post-operative International Index of Erectile Function (IIEF) and International Prostate Symptom Score (IPSS) urinary symptom scores, length of stay, margin positivity rates, PSAs at three and six months, the relative rate of post-surgical radiotherapy to the prostate bed and the rate of artificial sphincter insertion within two years of surgery.	Local provider
Is there a clinical audit dataset recorded for prostate radiotherapy? Measurements might include <ul style="list-style-type: none"><li>• mean nadir PSA stage for stage at one year</li><li>• rates of PSA failure (American Society for Therapeutic Radiology and Oncology (ASTRO) definition of an increase of 2ng/ml above nadir)</li><li>• potency rates at 12 months</li><li>• referral rates to surgeons/physicians for urinary and bowel toxicity</li><li>• use of neo-adjuvant hormone therapy for cT3 disease</li><li>• use and duration of adjuvant hormone therapy for cT3 disease.</li></ul> For advanced disease: <ul style="list-style-type: none"><li>• proportion of patients receiving chemotherapy for palliation</li><li>• number of palliative surgical interventions (nephrostomy/trans-urethral resection (TUR) channel).</li></ul>	Local provider

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Key commissioning questions for superficial bladder cancer	Where to find the answers
<b>Treatment</b>	
What is the provision of Bacillus Calmette-Guerin (BCG) ± maintenance as a percentage of the presenting patients within year 1?	Local provider

Key commissioning questions for invasive bladder cancer	Where to find the answers
<b>Team working</b>	
Are any radical cystectomies performed outside a specialist team centre? (There should be none.)	HES
<b>Treatment</b>	
What is the cystectomy rate?	HES
What is the number of neobladder reconstructions? (Procedure should be available and, when offered, be taken up by at least 20%.)	HES/local information
What is the use of pelvic node dissection? (A bit more difficult to measure and quantify.)	Local provider
<b>Length of hospital stay</b>	
What is the length of post-operative stay? (12–14 days)	HES

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Key commissioning questions for renal cancer	Where to find the answers
<b>Treatment</b>	
What is the proportion of nephron-sparing procedures for T1a disease? (Should now be most cases.)	Local provider
What is the recurrence rate/re-operation rate for nephron sparing? (Should be no more than 2%.)	Local provider
What is the ratio of laparoscopic vs. open nephrectomy for T1b and T2 disease? (The majority should now be done laparoscopically.)	Local provider
What is the percentage of advanced cases having debulking surgery and immuno/targeted therapy?	Local provider
What is the number of cases performed involving renal vein/inferior vena cava (IVC)? (Should not be carried out outside a designated and functioning specialist urological cancer team.)	Local provider
<b>Length of hospital stay</b>	
What is the length of post-operative stay? (Should be 7–10 days for uncomplicated cases.)	HES
<b>Incidence/mortality and survival</b>	
What is the 30-day mortality? (Should be <2%)	Cancer Registry

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Key commissioning questions for penile cancer	Where to find the answers
<b>Team working</b>	
Are all cases discussed and treatment plans agreed by a designated supra-network penile cancer team? (Men undergoing reconstruction and/or lymph node dissection must be operated on at the host hospital of the supra-network penile cancer team; no penile cancer cases should be treated by local urology cancer teams, apart from biopsies.)	Local provider
<b>Treatment</b>	
What is the proportion of patients undergoing partial amputation or organ preservation (glansctomy or radiotherapy) for T1 disease?	Local provider
What is the inguinal lymph node dissection rate for T2+/G3 disease?	Local provider

Key commissioning questions for testicular cancer	Where to find the answers
<b>Waiting times</b>	
What is the time from diagnostic primary surgery to first consultation with a supra-network testicular cancer team?	CWT

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Key commissioning questions for testicular cancer	Where to find the answers
<b>Treatment</b>	
What percentage of cases with stage 1 non-seminomatous disease is given adjuvant chemotherapy?	Local provider
What percentage of cases with stage 1 seminoma is offered adjuvant radiotherapy/low dose chemotherapy/active surveillance?	Local provider
What percentage of cases is undergoing retroperitoneal lymph node dissection for residual masses? (Should be one in five of men with stage 2+ disease.)	Local provider
What percentage of cases requires/receives salvage chemotherapy?	Local provider
What is the mortality rate?	CIS

Commissioning guidance on other cancers will be developed in due course.

## 6.3 Radiotherapy

### 6.3.1 What is radiotherapy?

External beam radiotherapy (teletherapy) is the delivery of radiation treatment to tumours, normally using a linear accelerator (linac). This is the most common form of radiotherapy and is the indicator included in the Cancer Commissioning Toolkit. Other forms of radiotherapy include superficial treatment either by lower energy x-rays or electrons, normally intended to penetrate only a short distance; and brachytherapy, which involves the insertion of radioactive materials into the patient.

Radiotherapy is delivered by therapy radiographers under the direction of clinical oncologists and with critical input from physicists. Treatment is normally divided into a number of fractions to reduce the daily radiation dose given to the patient. Radical treatments consist of more fractions and are of longer duration than palliative treatments.

The positioning and shape of the treatment volume are critical. Treatment simulators and treatment planning computers are essential in planning precise treatment. The current generation of linear accelerators is capable of delivering precisely shaped treatment (conformal

radiotherapy), which allows a higher dose to be given to the tumour while sparing the surrounding tissue.

Expert advice indicates that over 50% of all cancer patients should receive radiotherapy as part of their cancer treatment.

### 6.3.2 Key issues/background

The Cancer Reform Strategy endorsed the recommendations of the National Radiotherapy Advisory Group (NRAG), which was asked to advise ministers on:

- the current position on radiotherapy services in England
- how to ensure that current resources are deployed to best effect
- how to plan for a world-class service in the longer term.

NRAG's report was published in May 2007.

This, together with the published NRAG subgroup reports, is the key best practice guidance document for commissioners of radiotherapy services. All the documents are available at: [www.cancer.nhs.uk/radiotherapy](http://www.cancer.nhs.uk/radiotherapy)

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Another important source of information to support service improvement is the NHS Improvement website. A Guide to Radiotherapy describes radiotherapy processes and provides a glossary of terms.

The key messages in the NRAG report are that:

- the projected need for radiotherapy was significantly underestimated 15–20 years ago. There is now a large gap (63%) between current activity levels and optimal treatment levels if radiotherapy were to be given to all who might benefit (see the Royal College of Radiologists (RCR) document on the evidence base for appropriate fractionation regimens)
- the gap between current activity levels and optimal treatment levels will worsen, since cancer incidence is set to increase by a third by 2020 owing to the ageing population
- there are inequalities in access to radiotherapy treatment across the country, with a 2.5-fold variation in the number of fractions provided per million population between cancer networks (ranging from 17,500 to 48,000 fractions per million)

- access rates to radiotherapy in England (i.e. the number of patients diagnosed with cancer who receive radiotherapy) currently stand at 38%, compared with other countries where 52% of patients receive radiotherapy at some time in their illness. This means that, of the 275,000 cancer patients diagnosed each year in England, 36,000 patients who might benefit from radiotherapy do not receive it
- the critical challenge is to ensure that the workforce is adequate to deliver increased radiotherapy, and more staff are being trained and more use needs to be made by centres of the four-tier workforce model for radiotherapy, of assistants, practitioners, specialists and consultants. There is also a need to reduce attrition rates from those training in radiotherapy
- greater productivity could be achieved from linear accelerators if departments worked longer hours in the day and were open on more days
- waiting times for radiotherapy, where it is not the first treatment (and therefore not covered by the cancer 31 day and 62 day targets), remain long in some areas. There is evidence that this impairs treatment. For example, breast cancer patients who wait longer than eight weeks for post-operative radiotherapy have a 60% increase in local recurrence over five years (*British Medical Journal*, 2007, 34: 915)

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- providers of radiotherapy services to NHS patients should have a capital replacement programme in place. This also needs to ensure that equipment upgrades are included as appropriate.

### 6.3.3 Performance indicators

The key metrics and performance indicators derived from the NRAG report to guide commissioners as to the appropriate levels of service for their population and what they might expect from their providers are as follows:

- **by 2010/11, an interim goal of 40,000 fractions per million population** should be delivered by radiotherapy services, recognising the fact that workforce and linear accelerator capacity need to increase if expansion is to be achieved. (Note that this interim goal does not apply to London owing to population demographics)
- **by 2016, 54,000 fractions per million population (on average)** should be delivered by radiotherapy services. (There may be some legitimate regional variation owing to differences in cancer incidence)
- **by 2016, approximately 52% of patients diagnosed with cancer should be treated with radiotherapy at some stage in their illness**

- **patients should receive routine radical radiotherapy within 31 days** of being ready for treatment (this is a national requirement to be achieved by December 2010). Patients in need of palliative radiotherapy should be treated within 14 days; patients requiring urgent radiotherapy should be treated within 48 hours, as per RCR guidelines
  - **a radiotherapy service should be available within 45 minutes' travelling time for the majority of the population**, although it is recognised that this may not be possible in all areas
  - **linear accelerators should be replaced every 10 years** (a technical specification has been developed). Software should be upgraded every three years, to ensure accurate, high-quality treatment
  - **linear accelerators should be used to best capacity:**
    - 8,000 fractions per annum averaged across linacs in a department – as a current goal
    - 8,300 fractions per annum averaged across linacs in a department – by 2010/11
    - 8,700 fractions per annum averaged across linacs in a department by 2016
- The NRAG report offers advice to providers of services on how these levels of activity can be achieved.

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A range of measures that focus mainly on governance, leadership and safety are also set out in the Manual for Cancer Services. Key questions commissioners should

ask to assure themselves that they are commissioning high-quality radiotherapy services are set out below.

Key commissioning questions for radiotherapy	Where to find the answers
<b>Activity and access</b>	
How many fractions of radiotherapy are being delivered per million population served?	Local contracts if fractions used as currency; national radiotherapy equipment survey (2006/07); Outpatient Commissioning Dataset (OPCDS) to support Healthcare Resource Group (HRG) V4 for radiotherapy
If this is less than 40,000 fractions/million, what is the key limiting factor (e.g. staff, machines or both)? (Note that this excludes London.)	Local provider
What proportion of cancer patients in this locality/network receives radiotherapy? (It should be around 50%.) (Note that even if waiting times are being met, it is important to ensure that all patients have access to radiotherapy where appropriate, and that they also have access to appropriate levels of treatment.)	This can be measured by comparing the incidence of cancer (from Cancer Registry) with the numbers of patients treated with radiotherapy, but excluding those being re-treated (local services department). The current result of 38% in England indicates limited access
What proportion of patients has to travel longer than 45 minutes to access radiotherapy? Do any significant concentrations of population travel further than 45 minutes?	Mapping data from the National Cancer Services Analysis Team (NatCanSAT) or local GIS mapping of patient postcodes

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Key commissioning questions for radiotherapy	Where to find the answers
Does the network/unit have a realistic plan to deliver the NRAG recommendations?	Local plan in place
Is the service being commissioned by disease care pathways? Are service specifications in place?	Documentation supporting the development of service specifications by care pathways can be found at <a href="http://www.cancer.nhs.uk/radiotherapy">www.cancer.nhs.uk/radiotherapy</a>
<b>Waiting times</b>	
Are the current 31 and 62 day standards being met where radiotherapy is the first treatment?	Cancer waits database
What proportion of local patients waits longer than 31 days for radical treatment?	Royal College of Radiologists National Audit 2007. Radiotherapy dataset from April 2009 onwards, peer review measures
What proportion of local patients waits longer than 14 days for palliative treatment?	Royal College of Radiologists National Audit 2007. Radiotherapy dataset from April 2009 onwards
<b>Quality</b>	
Is there a network group for radiotherapy services?	Local network
How well do current service providers comply with peer review measures? Are agreed-quality Serious Untoward Incident reporting systems in place? Is action being taken to remedy deficiencies?	CQINs, local systems, Serious Untoward Incident reporting
Are there agreed dose fractionation regimes within the service and network?	Local policies

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Key commissioning questions for radiotherapy	Where to find the answers
Do dose fractionation regimes in local radiotherapy services meet best standards? Is the network policy included in the contracts? If fractionation regimes fall below the acknowledged evidence base for appropriate fractionation is there a recovery strategy agreed? Are agreed regimes consistently applied?	RCR guidance, local policies, local data, radiotherapy dataset (January 2009)
What is the equipment breakdown policy in the department? What percentage of patients has their treatment interrupted? Does the service meet RCR guidance for category 1, 2 and 3 patients?	Local provider/radiotherapy dataset from April 2009
Do local radiotherapy services have a 10-year replacement policy for linacs? Is there a clear, year-on-year, monitorable plan? Is software regularly upgraded?	Radiotherapy equipment survey 2007, NatCanSAT, local providers
<b>Provider productivity/sustainable growth</b>	
What is the productivity of your radiotherapy service in terms of fractions per annum averaged across all linacs? Fractions per hour (4.5 patients)?	Radiotherapy equipment survey, NatCanSAT, local providers
Do staffing levels in the radiotherapy services comply with national recommendations? Are staffing levels compromising full use of available equipment?	Local provider, radiotherapy equipment survey, NatCanSAT

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Key commissioning questions for radiotherapy	Where to find the answers
Does the local radiotherapy service have a sound workforce strategy to ensure that it can maintain service levels (e.g. four-tier model for therapeutic radiographer staffing; radiographer training; recruitment strategies)? What are the annual trainee radiographer wastage rates at the local higher education institute/school?	Local provider; local higher education institute
<b>Audit/data collection</b>	
Has the radiotherapy service got robust data collection and costing processes in place to support the introduction of HRG V4 for radiotherapy?	Reference costs returns to the Department of Health; OPCDS for radiotherapy; radiotherapy dataset project

### 6.3.4 Guidance on planning for service expansion

If service expansion is needed to ensure access to appropriate levels of radiotherapy for the population, commissioners will want to review the options:

- what is the increase in fractions required for the population by 2016? (To make good any shortfall in provision and address increasing incidence.)
- can the total of, or a proportion of, the required increase in activity be provided through more efficient use of the existing linacs? (See NRAG recommendations pp. 18–22; this solution is likely to require longer working hours and more radiographers and other staff.)

If additional linear accelerators are required to deliver an appropriate level of fractions to the population:

- has the lack of access to radiotherapy services been identified in a PCT/Local Authority Joint Strategic Needs Assessment and has the additional need for radiotherapy been systematically quantified by assessing local tumour incidence, stage of presentation and recommended fractionation regimes (see methodology in NRAG report)?
- have appropriate processes been put in place to engage the views of users, the local community

and, if appropriate, Overview and Scrutiny Committees (OSCs)?

- is there a case for developing an ambulatory satellite radiotherapy service to the existing service/centre in order to improve access to significant concentrations of population that live 45 minutes or more from the current service? This may be most appropriate for the delivery of routine radiotherapy, e.g. breast, prostate, lung. (Note that satellite/devolved services should always be developed in a way that facilitates integrated working with the existing providers of radiotherapy services, that uses the workforce most effectively and that allows sub-specialisation among oncologists to be maintained across the cancer network. See RCR publication *Guidance on the Development and Management of Devolved Radiotherapy Services*.)
- are there benefits in increasing linac capacity at the current centre (e.g. through more effective use of existing staff)?
- have network plans for the expansion of radiotherapy services been discussed with neighbouring networks through the specialised commissioning groups (SCGs) or SHAs to ensure that there is a 'good fit' for planned developments across the SCG, and that proposals do not impact

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on other network flows for services potentially undermining the critical mass required for specialist services?

- is Department of Health guidance for commissioners on procurement of services being followed?
- has consideration been given to the opportunity to explore innovative solutions that maximise ambulatory care and local access to cancer services in addition to radiotherapy, e.g. chemotherapy, diagnostic equipment, information centres, supportive care?
- do specifications/contracts with providers set out clearly when they are expected to be delivering radiotherapy services that meet the key performance indicators?

More detailed guidance on planning for service expansion has been circulated to the service. This is attached.

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## 6.4 Cancer systemic therapy

### 6.4.1 What is cancer systemic therapy?

The medical treatment of cancer involves the use of several distinct groups of drugs:

- cytotoxic drugs – these are the original anti-cancer drugs and include alkylating agents, cytotoxic antibiotics, vinca alkaloids and antimetabolites. More recent drugs such as platinum drugs and taxanes also fall into this group
- drugs affecting the immune response – this group includes corticosteroids and other immune suppressants, interferon and the new monoclonal antibody drugs
- hormones and hormone antagonists – hormone manipulation has an important role in the treatment of breast, prostate and endometrial cancer. This group includes oestrogens, progestogens, anti-androgens and more recent drugs such as aromatase inhibitors
- supportive drugs which do not have a direct anti-tumour effect – this group includes marrow-stimulating drugs, calcium-lowering agents and specialised anti-emetics. Complex antibiotic regimens also have an important role where treatment has resulted in marrow damage and a low resistance to infection.

Chemotherapy is given in standard, internationally recognised regimens, often containing a combination of drugs. Treatment is prescribed by medical and clinical oncologists and delivered by specialist chemotherapy nurses. The drugs for injection are prepared to an individual prescription by trained pharmacists using sealed cabinets, which minimise hazards.

Most regimens continue over several months and involve mainly day case attendance at a specialist clinic. In order to be effective, many drugs are given at the maximum dose tolerable and significant side effects should be anticipated. Some patients will encounter life-threatening side effects and will require emergency re-admission to a specialist unit. Some regimens, primarily hormones and hormone antagonists, may be continued in a primary care setting.

### 6.4.2 Key issues/background

PCTs have a responsibility to ensure that they are commissioning safe and effective systemic therapy services for their population, and that new treatments are being delivered in accordance with NICE guidance. PCTs will need to ensure that they have robust and fair processes in place for making decisions on drugs that have not yet been approved by NICE.

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The National Chemotherapy Advisory Group's (NCAG's) report *Chemotherapy Services in England: Ensuring quality and safety* has been produced for consultation. This, together with the associated subgroup reports, is expected to provide best practice guidance documents for commissioners of chemotherapy services.

It is hoped that this guidance will support commissioners in undertaking a baseline assessment with their providers. The Chemotherapy Planning Oncology Resource Tool (C-PORT) being rolled out across networks provides an important vehicle for developing a baseline of chemotherapy provision across a network.

### 6.4.3 Initial messages from the NCAG

(Note that this section will be updated following the publication of *Chemotherapy Services in England*.)

The challenges facing commissioners include how to respond to the:

- historic variation in the accessibility and organisation of services
- accelerating demand for systemic therapy
- toxicity of treatment and the growing need for effective management of complications, particularly out of hours
- need for coherence between the delivery of solid and haematological tumours

- variation in the use of inpatient beds for delivery of chemotherapy and the opportunity to liberate resources through a greater ambulatory approach
- better use of new technologies (e.g. supportive drugs to reduce complication rates, oral rather than IV treatments)
- need for adequate capacity to deliver systemic therapy (workforce and facilities)
- complexity of the pathway across providers and the need to secure continuity of care, with a clear governance framework to ensure patient safety.

Commissioning strategies should be built on a **baseline assessment** of the provision of chemotherapy for a population, including a review of the:

- drugs/treatments offered, against both NICE recommendations and other national evidence
- distribution and population coverage of the service
- environment in which the service is offered
- skills and capability of the teams in supporting patients who are faced with toxic treatments that have a wide range of challenging side effects
- impact services are having on patients' quality and quantity of life.

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In considering the options for the preferred local **model of service** for the provision of systemic therapy, commissioners will need to assess which model of provision enables:

- the strongest influence on securing consistency of approach
- clinical credibility in the services delivered (links and capacity to develop a strong research base)
- flexibility in the use of resources – offering choice in location and timeliness of treatment
- consistency in offering well trained staff
- the greatest ease for patients in moving between the relevant services and providers (which minimises the risk of patients being left in limbo and also duplication of effort).

Opportunities to **shape the supply of services** will need to be considered in the context of national standards and evidence-based pathways of care, which include:

- standards for **assessment and decision-making**:
  - decisions to treat being supported by patient access to a multidisciplinary team
  - information for patients on the range of treatments available being agreed by all clinicians and commissioners across the network

- services being available within an agreed time frame, and certainly within national targets for first treatment
- information on choice of provider, recognising the risks to commissioners in terms of securing fair and effective services, as well as continuity of support if outside the local cancer network.
- standards for **delivery**:
  - prescribing in line with NICE technology assessment guidance and network protocols
  - systemic therapy delivered within an agreed clinical governance framework (this may include shared-care arrangements across primary and secondary care)
  - equitable access for patients to clinical research trials and accrual rates, in line with national targets.
- standards for **managing complications**:
  - robust network-wide systems for the urgent management of patients:
    - out of hours
    - with neutropenic sepsis (infection when the white cell count is low)
  - reductions in the number of emergency admissions for all patients treated with chemotherapy

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- demonstrating proactive management of patients throughout their treatment to support any potential deterioration
- audit of patients who die within 31 days of chemotherapy treatment.
- standards for **inpatient care**:
  - comparison of the level of inpatient activity against national benchmarks.

A robust **performance management** framework will need to be underpinned with accurate and relevant information to demonstrate:

- compliance with the network-wide regimen list
- effective costing and coding mechanisms as part of the reference cost and activity collection process
- each organisation to provide an annually updated action plan as a result of the national peer review process for chemotherapy-specific measures
- improving patient experience within individual organisations and across networks
- efficiency and also to highlight local capacity constraints.

**Investment strategies** should be underpinned by a network-wide framework that provides advice on:

- changes to medicine cost, including any high-cost supportive drugs
- indications for the use of the drug against an agreed pathway; this should be in line with national best practice (at least benchmarked against other networks if national data are not available)
- the anticipated level of patient demand and any changes to the activity associated with administration
- horizon scanning for new drug treatments. Information on horizon scanning will be updated by network pharmacists each year in the Cancer Commissioning Toolkit
- how to proceed:
  - in handling drugs that have not yet been appraised by NICE
  - when there is a request to use a drug not licensed for a treatment
  - when drugs are currently in the process of being appraised (e.g. drugs approved in Scotland or widely used internationally) but are not currently approved in England.

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Risks associated with the introduction of a new national coding framework and **national tariff** for chemotherapy need to be mapped and handling strategies agreed in order to secure:

- consistency and accuracy of coding of Office of Population Censuses and Surveys classification of surgical operations and procedures (OPCS 4.4) across the cancer network (see: [www.connectingforhealth.nhs.uk/systemsandservices/data](http://www.connectingforhealth.nhs.uk/systemsandservices/data))
- the ability to audit HRG codes against agreed points on the clinical pathway (see: [www.ic.nhs.uk/casemix](http://www.ic.nhs.uk/casemix)) to limit the potential for attracting more income through increased contacts on multiple sites
- a shared approach to reference cost collection when services are delivered across more than one provider
- the agreed distribution of services across the health community and clarity around how financial risks are managed.

Given the complexity of the chemotherapy pathway, both in terms of the rate of development in treatment options and the number of organisations involved in the delivery of care, **cancer networks** should be

used to support the commissioning of chemotherapy by ensuring:

- a whole-systems, network-wide governance and accountability framework
- clearly agreed pathways and associated standards of care
- user and carer engagement to support the design and monitoring of chemotherapy services
- a common priorities framework for investment to minimise postcode prescribing across the network, with access to network pharmacy expertise to manage the process
- a process for identifying the impact of new and changing treatments (note that there is a chemotherapy planning capability in both the Cancer Commissioning Toolkit and in C-PORT)
- links between local commissioning strategies and those led by the specialised commissioning teams for blood and bone marrow transplantation and rare cancers
- clarity in the application of OPCS and HRG codes
- a prospectus that recognises a network approach to both the delivery and the commissioning of chemotherapy.

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Key questions commissioners should ask to assure themselves that they are commissioning high-quality chemotherapy services are set out below.

Key commissioning questions for chemotherapy	Where to find the answers
<b>Activity and access</b>	
<ul style="list-style-type: none"> <li>• How many chemotherapy treatments are delivered per 100,000 population? How does this compare with other PCTs in the network?</li> </ul>	<ul style="list-style-type: none"> <li>• Access contract data/OPCS 4.4 codes – these should be available on the Patient Administration System (and then by HRG through Secondary User Service) or the local e-prescribing database</li> <li>• OPCS codes are not tumour site specific, but they do provide information on IV and oral therapies (separate codes available)</li> <li>• Commissioners need to know which networks support their population</li> </ul>

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Key commissioning questions for chemotherapy	Where to find the answers
<b>Where are chemotherapy services delivered? What proportion of chemotherapy is delivered at the centre? Could more be delivered closer to home?</b>	
<ul style="list-style-type: none"><li>• Is there a network-agreed list of regimens and indications to reduce variation in practice?</li><li>• Is there a system in place to approve and manage changes to this list on an ongoing basis?</li><li>• Are the drugs used in line with this policy?</li><li>• How does usage of NICE-approved drugs compare with national figures?</li><li>• What action is being taken if there is a deficiency in this area?</li></ul>	<ul style="list-style-type: none"><li>• Trusts with no electronic chemotherapy system may have to provide this manually (sample data); however, access to a trust- or network-wide e-prescribing system would provide a full set of data to analyse drug usage against agreed pathways</li><li>• Network pharmacy expertise should be used to analyse the data and provide exception reports to commissioners</li></ul>
<b>Entry into clinical trials</b>	
<ul style="list-style-type: none"><li>• What proportion of patients has access to clinical trials?</li><li>• What are the accrual rates to randomised clinical trials?</li><li>• What proportion of network-approved trials is open?</li><li>• What obstacles are there to opening studies?</li></ul>	<ul style="list-style-type: none"><li>• Look for an accrual rate of at least 10% of incidence – Key Performance Indicators to be in line with national targets</li><li>• Trust and Cancer Research Network reports to provide the overview</li></ul>

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Key commissioning questions for chemotherapy	Where to find the answers
<b>Waits</b>	
<ul style="list-style-type: none"><li>• Are the current 31/62 day targets being met for patients receiving chemotherapy as a first treatment?</li><li>• What are the overall waiting times for their chemotherapy as a subsequent treatment?</li></ul>	<ul style="list-style-type: none"><li>• Performance reports – local waiting times data in the unit/MDT data (Note that the waiting time target is expanding from first to all treatments, and data should be available against agreed local and national definitions)</li></ul>
<b>Quality and safety</b>	
<ul style="list-style-type: none"><li>• Are patients discussed within an MDT before they receive their drug treatments? Is there any differentiation between first and subsequent treatments?</li><li>• What proportions of patients in relapse get access to an MDT assessment prior to treatment?</li><li>• Do all patients with end-stage disease (metastatic or progressive disease) have access to a specialist palliative care assessment and support team?</li></ul>	<ul style="list-style-type: none"><li>• Peer review reports (see CQuINS) will provide information on patients discussed at MDT; however, this is only likely to show those for whom chemotherapy is a first treatment. Manual data should be sought for patients in relapse</li><li>• Trusts must provide evidence to demonstrate the use of specialist palliative care teams to support decision-making for patients with metastatic or progressive disease – linked to local care pathways</li></ul>
<b>Patient Central Services</b>	
<ul style="list-style-type: none"><li>• Have you any data on the views of patients and what concerns they might have?</li><li>• Is the chemotherapy environment appropriate?</li></ul>	<ul style="list-style-type: none"><li>• Patient surveys (CQuINS)</li><li>• Visit to site</li></ul>

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Key commissioning questions for chemotherapy	Where to find the answers
<ul style="list-style-type: none"><li>• What wider supportive care is available and how are patients monitored throughout treatment?</li><li>• How does the chemotherapy team ensure that those receiving drug treatments are well supported through education – signs and symptoms management/early alerts?</li></ul>	<ul style="list-style-type: none"><li>• There should be an out-of-hours strategy in place to secure support for patients 24 hours a day, 7 days a week</li><li>• Trusts should be able to provide patient information and protocols for supporting patients</li></ul>
<ul style="list-style-type: none"><li>• Is there a clear pathway and policy for accessing oncology and haematology advice out of hours?</li></ul>	<ul style="list-style-type: none"><li>• Network-wide out-of-hours policy</li><li>• Audit programme</li></ul>
<ul style="list-style-type: none"><li>• How many patients die within 30 days of commencing a course of chemotherapy?</li></ul>	<ul style="list-style-type: none"><li>• This will be difficult to collect; however, the figures could be found from an audit of hospital deaths against those known to the chemotherapy service</li></ul>
<ul style="list-style-type: none"><li>• What is the occurrence of neutropenic sepsis requiring admission?</li><li>• How does this compare with other providers (recognising that you need to compare like with like)?</li></ul>	<ul style="list-style-type: none"><li>• Data should be looked at across the network, considering those with a diagnosis of cancer. This may need collective accountability between centres and units</li></ul>
<ul style="list-style-type: none"><li>• Is chemotherapy administered within settings that meet the requirements of the national governance framework?</li></ul>	<ul style="list-style-type: none"><li>• Trust self-assessment against chemotherapy measures</li><li>• The Manual for Cancer Services 3c-300 measure for intrathecal chemotherapy addresses the environment and is reported in the Cancer Commissioning Toolkit (Treatment section)</li></ul>

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Key commissioning questions for chemotherapy	Where to find the answers
<ul style="list-style-type: none"><li>• How well do chemotherapy services comply with peer review measures?</li></ul>	<ul style="list-style-type: none"><li>• Annually updated action plan as a result of the national peer review process for chemotherapy-specific measures</li><li>• CQuINS, local systems</li></ul>
<ul style="list-style-type: none"><li>• Are there agreed quality reporting systems in place?</li></ul>	<ul style="list-style-type: none"><li>• Serious Untoward Incidents related to the delivery of systemic therapy</li></ul>
<b>Effectiveness</b>	
<ul style="list-style-type: none"><li>• How well do your providers utilise their resources?</li><li>• How does this compare across the network/nationally?</li><li>• Is the current workforce and physical capacity sustainable, given current rising demands?</li><li>• Are there any bottlenecks in the pathway?</li></ul>	<ul style="list-style-type: none"><li>• Seek benchmarking data from trusts' capacity planning tool known as C-PORT</li><li>• Waiting time data for diagnostics as well as treatment</li></ul>
<ul style="list-style-type: none"><li>• Is there a clear pathway of care, highlighting the roles and responsibilities of each constituent player?</li></ul>	<ul style="list-style-type: none"><li>• Operational policy available for the support of chemotherapy management</li><li>• CQuINS provides access to network and trust response to Manual for Cancer Services</li></ul>



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Key commissioning questions for chemotherapy	Where to find the answers
<ul style="list-style-type: none"><li>• Are there clearly defined chemotherapy protocols and are they in line with best practice?</li><li>• Is there a system to approve and manage these protocols on an ongoing basis?</li></ul>	<ul style="list-style-type: none"><li>• CQuINS provides access to network and trust response to Manual for Cancer Services</li></ul>
<ul style="list-style-type: none"><li>• Is there a clear policy about which procedures and regimens should be managed on an ambulatory/inpatient basis?</li></ul>	<ul style="list-style-type: none"><li>• Seek local network-agreed policy against which to set local service specifications</li></ul>

#### 6.4.4 Guidance on planning for service expansion

There continues to be concern nationally around a lack of service capacity to support the rise in demand for chemotherapy. This includes insufficient chemotherapy nurses, too little space to administer therapy and, in many cases, limitations on pharmacy capacity to supply the drugs in a safe and timely way.

##### *Managing resources better*

In some parts of the country, NHS Trusts/Foundation Trusts are exploring a range of scheduling and capacity tools to see how they can maximise benefit to the patient and use their resources more effectively. The rollout of the national capacity modelling tool, C-PORT, offers a means of benchmarking provider performance across the country.

This tool can also help plan for the introduction of new drugs, including mapping changes in activity levels and understanding the impact of replacing intravenous with oral treatments.

Most patients should be able to receive their chemotherapy in an ambulatory setting – ranging from cancer centres to local hospitals or, in some cases, their own home. Inpatient care for both solid tumour and haemato-oncology patients should only be for those most vulnerable patients who may require very complex treatment.

New workforce models are also emerging, with extended roles for both nurses and pharmacists.

### *Adding capacity*

Traditionally, the main providers of NHS-funded chemotherapy services have been NHS oncology centres and local hospitals. In some parts of the country, however, PCTs and the independent sector have both become involved in the provision of chemotherapy, particularly in community and home care.

The expansion of new entrants for providing this service could be an option in areas where there are capacity constraints or where there is a need for new ways of working that offer a different philosophy and added value to the patient experience (e.g. alongside more supportive care).

In some cases, the use of external providers for drug preparation can also offer economies to a local health community.

## 6.5 Cancer Commissioning Toolkit metrics

The Cancer Commissioning Toolkit contains the following related metrics. These can be found by accessing the corresponding chapter **Treatment** and sections **Waiting Times**, **Radiotherapy**, **National Audit Participation** and **Cancer Medicines** plus chapter **Quality of Service** and section **Key Issues from Peer Review**, either via the dashboard or the contents page.

More information is currently being developed, and this will initially be placed on 'microsites' available to NHS net users.

### **Waiting Times**

- TWR performance
- TWR performance, time trend
- percentage of TWR with cancer diagnosis
- number of TWR with cancer diagnosis
- 31 days performance
- 31 days performance, time trend
- percentage of all cancer cases not referred as TWR
- percentage of all cancer cases not referred as TWR, time trend
- 62 days performance
- 62 days performance, time trend.

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### Radiotherapy

- radiotherapy: Number of fractions per million population
- radiotherapy: Average fractions per linear accelerator per year
- radiotherapy: % compliance with 3E measures. Manual for Cancer Services.

### National Audit Participation

- national audit participation.

### Cancer Medicines

- horizon scanning
- projected cost of upcoming NICE/SMC/AWMSG approvals
- activity planning
- chemotherapy services: % compliance with 3C-1 measures (Manual for Cancer Services)
- chemotherapy services: % compliance with 3C-2 measures
- chemotherapy services: % compliance with 3C-3 measures.

### Key Issues from Peer Review

- compliance with all MDT measures
- named core team members
- core team members present at meeting
- commissioning measures
- network user group measures.

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## 7. Commissioning to transform cancer inpatient care and move to ambulatory models of care

### 7.1 Background

In the year leading up to the Cancer Reform Strategy, NHS Improvement, the National Cancer Action Team and the NHS Institute conducted a number of studies and pilots to look at ways of improving inpatient care. This workstream is still in its early stages, but already the learning has identified huge potential for improving:

- the quality of inpatient cancer care
- the productivity of inpatient care, reducing unnecessary hospital use
- length-of-stay management.

It is envisaged that the right treatment, given in the most appropriate setting by staff with the necessary skills in a timely and proactive way, will provide a better experience of care for patients and will prove more cost-effective for the NHS.

The newly-announced Transforming Inpatient Care Programme, a feature of the Cancer Reform Strategy, will focus initially on providing practical support and guidance on four workstreams for different patient categories. These are as follows:

- **reducing the length of elective surgical admissions and associated readmissions**, including, in some instances, moving to day-case surgery. Acute trusts will want to lead on this programme at a local level, supported by their local Cancer Network Team, since reductions in length of stay will make their services more cost-effective against tariff
- **reducing the number and length of elective medical admissions, particularly those under haematologists or medical/clinical oncologists**, and in some instances avoiding inpatient admissions altogether by providing care in ambulatory settings. The local cancer network team, in collaboration with oncology centres and haematology services, will be well placed to lead this programme on behalf of Primary Care Trusts (PCTs) within the network. These specialties account for 25% of all elective cancer admissions
- **reducing the number of emergency admissions due to side effects of treatment (such as chemotherapy or radiotherapy) or progressive disease**. The aim is that, with more proactive management of patients' symptoms and side effects and with better patient education, problems can be identified early and managed on an ambulatory basis. PCTs and practice-based commissioners will need to be closely involved in

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this aspect of the work to establish symptom care pathways, for example for the management of breathlessness or urinary retention. PCTs/practice-based commissioners and cancer networks will also need to work with acute trusts and community providers to put in place systems to proactively manage patient symptoms in order to avoid inappropriate admissions and reduce overall length of stay

- **supporting the more rapid diagnosis of patients presenting with symptoms that may be due to cancer.** The NHS Institute for Improvement and Innovation has led a project in this area and will be publishing its key recommendations in the winter.

The aim is to:

- address the problem by raising the population's and GPs' awareness of early signs and symptoms of cancer
- understand better the pathway/history of patients being admitted as emergencies due to undiagnosed cancer
- provide support to GPs who access urgent advice and if possible put patients on to a very fast-track diagnostic pathway
- ensure that accident and emergency staff are supported to make a diagnosis prior to admission.

### 7.1.1 Why focus on inpatient care?

- it matters to patients:
  - most patients have at least one admission during their treatment
  - it is an opportunity to improve the patient experience
  - emergency admissions can be a particularly frightening and bewildering experience for patients
  - it is about valuing patients' time
- England has higher bed utilisation for cancer than other countries:
  - inpatient costs account for a large proportion of the total cancer expenditure
  - reducing inpatient bed days/admissions provides an opportunity to redirect resources into other areas of cancer care
- inpatient admissions for cancer have risen by 25% in the last eight years and the number of bed days is rising by 1% each year. Inpatient costs will increase by 24% in the next 15 years due to the increased incidence of cancer, unless action is taken to avoid this
- inpatient care has received very little attention to date, for the following reasons:
  - we have mostly focused on referral to first treatment
  - it was not an area covered by National Institute for Health and Clinical Excellence (NICE) guidance or the NHS Cancer Plan of 2000

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- we know very little about patients' experience of their inpatient care. An important workstream will be to survey patient experience and ask patients to record their experiences in patient diaries
- PCTs will be monitored against selected Vital Signs indicators to identify how the NHS is performing locally and nationally. This includes the number of emergency bed days per head of weighted population.

The Cancer Commissioning Toolkit will provide benchmarked information to support analysis of all the above areas, enabling networks and PCTs to gain an overview of their local bed usage. It also provides signposts to supportive information on tested improvements that can be adopted to improve the quality and efficiency of the inpatient pathway.

## 7.2 Key issues drawn from the national overview of inpatient care

- inpatient care for patients diagnosed with cancer accounts for 12% of all inpatient bed days in England
- on any single day, some 14,550 cancer patients are in a hospital bed. This equates to around 29 occupied beds per 100,000 population, and

around 435 beds occupied by patients with cancer in an average sized network with a population of 1.5 million. If bed occupancy were maintained at 80%, this would be the equivalent of 500 hospital beds in an average network dedicated to the treatment of cancer patients each day

- it is important to recognise that the majority of cancer inpatients are under the care of general medicine, care of the elderly and surgery. Lower numbers are under the care of haemato-oncology, clinical oncology and medical oncology
- inpatient admissions have risen by 25% in the last eight years (from 625,000 to 785,000 per annum)
- emergency inpatient admissions for cancer have risen fastest, with an increase of 47% over the past eight years (the equivalent rise in elective admissions has been 8.6%)
- the average length of stay has fallen, but bed days for cancer are rising by 1% each year:
  - emergency bed days are rising by 2.5% each year
  - elective bed days are falling by 1% each year
- some 60% of all cancer admissions are elective, but they use 40% of bed days
- some 40% of all cancer admissions are emergencies, but they use 60% of bed days

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- some 25% of all cancer emergency admissions have a length of stay above the Healthcare Resource Group (HRG) trim point
- some 20% of all cancer emergency admissions are at the end of life, with the patient dying in hospital
- inpatient care represents 52% of all expenditure on cancer, which stands at a total of £4.35 billion each year:
  - 27% of inpatient costs relate to non-surgical stays (excluding the costs of drugs)
  - 22% of inpatient costs relate to surgery (including day cases and inpatient stays)
- inpatient costs will increase by 24% over the next 15 years due to the increased incidence of cancer in an ageing population. In order to keep inpatient costs at the same level:
  - the average length of stay must fall by one third; or
  - emergency admissions must be halved.

The starting point for PCTs/networks is to develop an overview of their local bed use on a resident and provider basis. Suggested key questions to be asked are set out in the following sections.

### 7.3 Developing an overview of cancer inpatient care in local NHS Trusts and NHS Foundation Trusts (individually and aggregated by network and Strategic Health Authority)

#### *Key commissioning questions*

- how many beds in the hospital/trust does a cancer patient occupy on any one day (emergency and elective)? (Source: Hospital Episode Statistics (HES) occupied beds (i.e. total bed days due to cancer in a year ÷ 365)/Cancer Commissioning Toolkit)
- how many bed days/beds does this amount to each year (emergency and elective)? (HES)
- how many emergency/elective finished consultant episodes (FCEs) each year of the total trust activity are due to cancer – as a measure of the proportion of activity cancer represents for the trust?
- what is the difference across the tumour types for all the above (percentage share)?
- which specialties are responsible for managing inpatients with cancer?
- what is the average number of excess bed days above the HRG trim point (emergency and elective benchmarked) per admission?
- what is the approximate cost of cancer inpatient care in the trust in total and for each type of tumour?

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- how many intensive therapy unit/high dependency unit (ITU/HDU) beds are used for patients with cancer?
- what proportion of the hospital/trust's activity is due to cancer in each specialty?
- what national/local information is there about cancer patients' experience of inpatient care, for example for haematology and oncology services in each trust?
- have patients' views about the inpatient experience been surveyed?

#### 7.4 Developing a local overview of cancer inpatient care for the resident population of the Strategic Health Authority/Cancer Network/Primary Care Trust/Local Authority

##### *Key commissioning questions*

- how many of the resident population are in hospital due to cancer on any given day (emergency and elective per 100,000 population)?
- how many emergency/elective episodes (FCEs) are due to cancer each year?
- how many excess cancer bed days (emergency and elective over the trim point) is the PCT funding?

- how much do these cost and how do we compare with elsewhere (benchmark by cancer incidences)?
- what is the share of beds used for each of the main tumours?
- what PCT activity and cost is going to each trust by type of tumour?

#### 7.5 Strategies for reducing unnecessary hospital use by different patient categories

##### 7.5.1 Elective surgical patients and associated emergency readmissions

##### *Key commissioning questions*

- how many bed days can be saved if the trust or trusts in the network operate at the upper quartile performance for length of stay in key operations? How can bed capacity be released and savings reinvested elsewhere?
- where can the greatest gains be made, by trust or by type of tumour? How can things be done differently?
- how can the length of stay be reduced?
- can care be provided in alternative ways (for example moving from inpatient to day case to outpatient)?

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### Metrics

Benchmarked length of stay by specific procedures – by trust/network (provider) detailing:

- pre-operative bed days
- post-operative bed days
- bed days above trim point and cost
- upper quartile performance calculation regarding potential bed savings.

Quality/efficiency indicators include:

- days in ITU/HDU
- readmission rates and complications.

### Key actions

- develop pre-admission clinics/systems
- ensure that diagnostic tests are completed prior to admission
- Plan and ensure an integrated discharge package; refer early to other supportive agencies
- ensure that complex discharge issues are brought to the multidisciplinary team (MDT) for multidisciplinary decision-making and multi-agency solutions

- define timed care pathways, with proactive daily decision-making and clear escalation triggers
- ensure a team approach to care/discharge that is supported by protocol
- priority areas for change are to move to:
  - day case/23-hour breast mastectomy
  - laparoscopic colorectal surgery with enhanced recovery
  - open surgery with enhanced recovery
  - same-day admission for surgery.

### 7.5.2 Elective oncology admissions

The three specialities of medical oncology, clinical oncology and haematological oncology account for 25% of all cancer elective admissions.

#### Key commissioning questions

- does the patient need to be treated as an inpatient? For example, can long infusions be given in the course of two separate visits to an ambulatory chemotherapy service?
- is the length of stay appropriate?

### Metrics

- number of bed days under clinical/medical oncologists per 100,000 population in network

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of residence. (Note that this metric needs to be assessed together with overall bed usage in the network, as hospitals have different policies about admission to oncology or general medicine beds.)

- benchmarked number of inpatient stays of two days or less, where chemotherapy is the purpose of admission, by trust/network of provision
- number of bed days where radiotherapy is the purpose of admission, by network (resident-based)
- top-10 causes of admissions, benchmarked, for haematology.

#### Key actions

- agree a list of regimens that can/should be given on an outpatient basis, and safe models of delivery
- develop models/exemplars for giving long infusions (chemotherapy and hydration therapy) on a day-care basis (e.g. bring patient in on consecutive days for infusions/hydration)
- assess the potential for hostel accommodation
- give as much systemic therapy as possible on an outpatient/day basis – assess impact through use of C-PORT
- introduce 'on-call oncologist' systems and daily ward rounds to ensure that there are no delays in discharging patients. (This can currently be a

problem, as oncologists spend much of their time visiting other hospitals.)

More analysis will be undertaken on the top 10 causes of admission as the Transforming Inpatient Care Programme rolls out.

### 7.5.3 Reducing emergency admissions for patients with known cancer and treatment side effects

#### Key commissioning questions

- what is the annual increase in emergency admissions/bed days for my population?
- can the adverse side effects of treatment be better controlled?
- can the adverse side effects of treatment be recognised earlier and managed in an inpatient setting, reducing the need for patients to be managed in an ambulatory setting and pre-empting the need for emergency admission?
- do patients have clear, agreed ways to re-access the services?
- is appropriate, skilled support available from community/hospice services?
- are patients being helped to make choices about where they wish to die? (25% of emergency admissions end in death.)

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### Metrics

- number of cancer emergency admissions per 100,000 unified weighted population. (Note that it is difficult to exclude undiagnosed patients from this metric.)
- common causes of admission are:
  - febrile neutropaenia/neutropenic sepsis
  - diarrhoea
  - nausea/intractable vomiting
  - anaemia
  - pain
  - retention of urine/haematuria
  - shortness of breath/dyspnoea
  - drainage of ascites.

### Key actions for patients on active treatment

- agree emergency symptom pathway
- develop protocols for supportive care, e.g. nutrition/granulocyte-colony stimulating factors (GCSF) to prevent side effects
- give comprehensive patient education to help patients/carers to recognise and manage symptoms
- give patients/professionals access to an emergency admission communication alert system/on-call oncologist

- monitor patients proactively (for example with telephone calls) for the early detection of problems
- manage side effects/problems on an ambulatory basis (e.g. bring patients into a chemotherapy suite for hydration/antibiotics)
- if admission is necessary, manage the admission direct to an agreed location, i.e. avoid accident and emergency (develop a policy about where assessment and treatment can be given and by whom)
- where possible, don't admit: stabilise the patient and bring them back for treatment in an ambulatory setting
- develop staff with generic oncology skills to support patient assessment
- develop an agreed emergency symptom pathway:
  - where should patients go?
  - who can treat patients?
- define when a patient should be admitted and to where.

### Key actions for patients with progressive diseases

- set up a central, 24-hour emergency oncology clinical advisory service for GPs/accident and emergency/clinicians in district general hospitals

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- establish systems for liaison with palliative care/ community matrons
- develop intermediate care services, recognised care homes/hospices
- establish good links with rehabilitation services and rapid access to equipment
- ensure that patient follow-up arrangements:
  - provide patient education on how to re-access services
  - promote self-management of symptoms and recognition of signs of disease progression.

#### 7.5.4 Emergency admissions for patients who are first diagnosed with cancer during their stay

##### *Key commissioning issue*

In a more engaged healthcare system, more people would be diagnosed through elective pathways. Common cancers presenting as emergencies are lung, colon, brain and acute leukaemias.

##### *Metrics*

- the number of emergency admissions without a known cancer but where the patient is diagnosed with cancer on that admission – per 100,000 unified weighted resident population, by Strategic Health Authority/PCT/network of residence (or by cancer incidence).

##### *Key actions*

- develop an algorithm to support decision-making in accident and emergency or primary care
- set up an emergency communication alert system service for GPs/accident and emergency/clinicians in district general hospitals to enable rapid specialty assessment and arrangement of outpatient investigations
- support GPs to stabilise patients at home and arrange to fast-track (i.e. quicker than two weeks) patients through an 'emergency rapid-access clinic'. (Put in place a policy for MDT co-ordination of this.)
- in the case of assessment in accident and emergency/surgical admissions unit/medical admissions unit, don't 'admit to assess' but rather 'assess the need to admit', through a well defined algorithm and with ready access to diagnostic tests:
  - either stabilise and discharge the patient, having booked tests for investigation on a planned pathway with navigation support; or
  - if there is a need to admit, the decision should be taken by a senior consultant, with a management plan for the hospital ward to carry out, supported by a speciality oncologist on-call advice-line and with a consultant visit within 24 hours, if required

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- gain an understanding of the pre-emergency admission pathway
- have policies in place for the management of unknown primary tumours (work is currently being undertaken on this by NICE).

### 7.5.5 Commissioning to reduce inpatient admissions

Department of Health guidance has been published to support reductions in emergency admissions and hospitalisation: Care and resource utilisation – Ensuring appropriateness of care.

Care and resource utilisation (CRU) is linked to clauses in the National Contract for Acute Providers, and detailed expectations of commissioners and providers are set out in Schedule 3 of the contract. Reduced activity schedules should be defined and formally monitored on a monthly basis.

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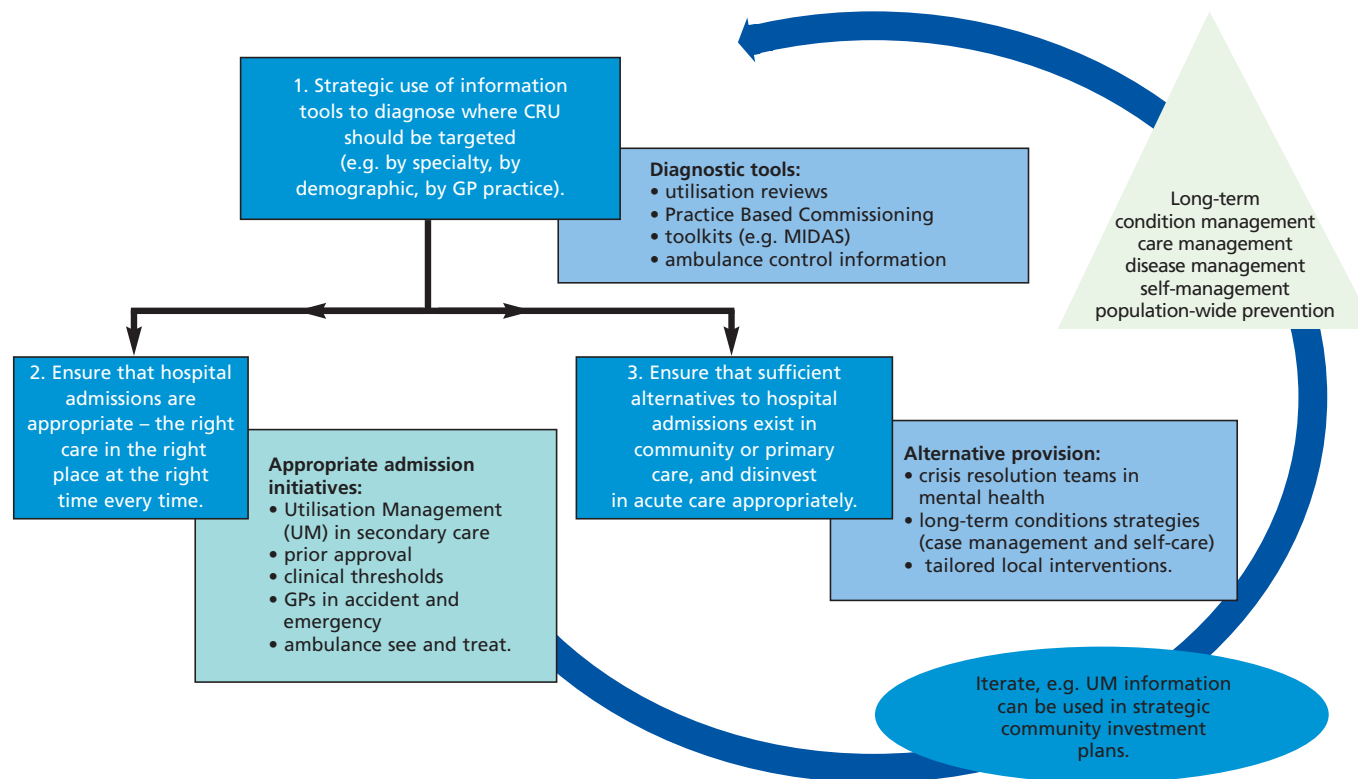
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A successful CRU strategy should consist of three elements, as shown below:



Examples of elements of a successful CRU strategy for reducing cancer inpatient care include:

- **resource utilisation:**
  - list procedures that should be managed on an ambulatory basis
  - list procedures/regimens where it is appropriate to admit to inpatient care.
- **care management processes and facilities include:**
  - algorithms for assessment
  - oncologist advice-line/on call
  - designated locations for care (e.g. neutropenic sepsis/hydration)
  - links with palliative care/community support services for patients
  - proactive monitoring/patient education
  - put patient back onto planned care pathways (i.e. discharge with follow-up dates)
  - protocols for managing side effects.

#### 7.5.6 Who needs to be engaged in the inpatient/ambulatory care management programme?

1. Cancer networks and commissioners, including practice-based commissioners, via:

- toolkit and metrics
- demonstration projects with NHS Improvement

- discussions regarding contracts – an expectation regarding reduced admission is set out in explicit terms
- setting up monitoring systems with operations directors in trusts
- audits of appropriateness of emergency admissions/inpatient care
- commissioning/contracting development programmes.

2. Oncologists (haematologists, clinical oncologists, medical oncologists, chest physicians and other medical specialties, who can:

- develop treatment protocols for supportive care
- establish 24-hour on-call advice lines
- see all patients within 24 hours if admitted to any trust in the network
- develop models for ambulatory care
- consider oncology admission units at cancer centres to avoid accident and emergency.

3. Surgical oncologists, who can:

- develop pre-admission systems, including discharge planning
- develop inpatient care pathways
- establish team, protocol-driven, decision/discharge systems.

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4. Accident and emergency – medical admissions unit, which can:

- develop algorithms to support assessment
- ensure senior, swift decision-making by clinicians
- stabilise and discharge if possible and put on care pathway
- ensure that management is in place before admission to ward
- throughout, ensure rigorous decision-making systems prior to admission.

5. Nurses, cancer nurses, chemotherapy, clinical nurse specialists, generic oncology, who:

- can provide a workforce that is available for longer opening hours, such as 8am–8pm
- have the skills and competencies to manage ambulatory care facilities, e.g. nurse practitioner-type roles in medical oncology
- provide patient education
- ensure proactive management and telephone follow-up.

6. Allied health professionals, who provide, for example:

- nutritional support/dietetics
- rehabilitation for progressive disease/late effects.

7. GPs and community teams/facilities, who:

- develop and support step-down facilities
- provide 24-hour advice from oncologists/clinical nurse specialists
- ensure protocols and system management
- provide skilled community teams.

8. Palliative care services, which:

- use symptom management protocols
- ensure best fit between location of care and complexity of care
- agree criteria for admission and consistent thresholds for services.

9. Social workers

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## 7.6 Cancer Commissioning Toolkit metrics

The Cancer Commissioning Toolkit contains the following related metrics. These can be found by accessing the corresponding chapter **Transforming Inpatient Care** and sections **Provider Activity and Efficiency** and **Inpatient Activity by Resident Population**, either via the dashboard or the contents page.

### Provider Activity and Efficiency

- provider: Annual share of cancer bed days by cancer type
- provider: Annual share of cancer bed days by trust
- provider: Annual share of cancer bed days by specialty
- provider: Share of daily occupied beds by cancer type
- provider: Share of daily occupied beds by trust
- provider: Share of daily occupied beds by specialty.

### Inpatient Activity by Resident Population

- inpatient: Bed days per 100k unified weighted population
- inpatient: Bed days per 100k unified weighted population, trend analysis
- inpatient: Daily occupied beds per 100k unified weighted population
- inpatient: Normalised occupied beds by 100k resident population, trend analysis
- inpatient: Excess bed days per 100k unified weighted population
- inpatient: Excess bed days by SHA, PCT and Network
- inpatient: Excess bed days and cost by specialty
- inpatient: Excess bed days and costs by cancer type.

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## 8. Commissioning improved services for people living with and beyond cancer

### 8.1 Overview

Defining standards for improving patient experience in contract schedules for cancer and other patients is in its infancy within the NHS. However, the National Institute for Health and Clinical Excellence (NICE) Supportive and Palliative Care (SPC) Guidance has helped to shape and formalise the agenda. Key recommendations of the guidance need to be included in service specifications/contract schedules covering the following areas:

- co-ordinated care within and across organisations with the patient being clear about whom to contact for support, especially out of hours
- high-quality patient information to aid decision-making about treatment options and where treatment might take place
- effective face-to-face communications between professionals and patients
- individual, holistic patient needs assessment
- access to supportive and holistic services
- culturally sensitive service provision/availability

- routine data collection on patient experience across the patient pathway
- assessment on completion of treatment, supported by an individual plan for ongoing support and follow-up.

This guidance is intended to begin the process of setting out some key principles in a number of areas which will require further development over time as data collection methods and datasets become more established, feeding standard quality indicators and measurement. The measures included should, therefore, be viewed as ‘work in progress’ to be developed and strengthened as schedules in contracts become more sophisticated and established practice with the commissioning process.

#### 8.1.1 Information and improved patient experience – the challenge

The National Audit Office (NAO) published a series of reports that addressed the progress that had been achieved through the NHS Cancer Plan. The NHS Cancer Plan: A Progress Report, Tackling Cancer: Improving the Patient Journey and Tackling Cancer in England: Saving More Lives, together with the findings from the national cancer survey in 2002 and a subsequent NAO cancer patient survey in 2004, identified that there is still much more to be done to improve the experience of cancer patients.

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The key messages from the combined NAO reports, national cancer patient surveys and NICE SPC Guidance are that:

- prostate cancer patients have a worse experience of cancer services than those with other cancers
- 40% of patients did not receive printed information about their diagnosis
- 1 in 5 patients reported that they did not receive printed information on discharge from hospital
- patients who do not have English as their first language have particular problems with receiving suitable information
- most patients reported that they lacked access to advice about financial benefits to support them during or after illness
- 40% of patients did not receive information about support groups
- commissioners and service providers should ensure that patients and carers have easy access to a range of high-quality information materials about cancer and cancer services.

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## 8.2 Commissioning patient information services

A clear focus on improving patient experience is still limited as very few datasets or metrics are currently available to drive up improvements or measure success. To this end, a suggested baseline assessment of infrastructure capacity to deliver the patient information agenda has been developed. Work to establish information metrics will begin in 2008.

Key commissioning questions for patient information services	Data source
Can the service provider demonstrate through audited records that at least 80% of patients receive information about their diagnosis?	Local provider reporting system
Do patient records identify that information has been: <ul style="list-style-type: none"><li>• offered to patients?</li><li>• accepted or declined?</li><li>• dispensed by a named healthcare professional?</li></ul>	Local provider reporting system
Is there an appropriate auditable system in place that can identify the stage within the pathway when information was offered/received?	Local provider reporting system
Is there an appropriate range of information available at the key stages of the patient pathway? (As demonstrated in the core national information pathways (from August 2008).)	Local provider reporting systems
Can the provider demonstrate through patient surveys that at least 80% of patients can recall being given information on discharge?	Patient surveys

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Key commissioning questions for patient information services	Data source
Are staff trained to deliver patient information at key stages of the patient journey?	Local provider workforce strategy/training action plan records
Is there a systematic process in place for assessing and recording the information needs of patients that is then recorded on the patient record with media preferences identified?	Local provider reporting
What arrangements are in place to ensure the smooth transition of patient information needs across the interface between secondary and primary care?	Patient surveys

### 8.3 NICE Supportive and Palliative Care Guidance

NICE Supportive and Palliative Care (SPC) Guidance was produced in March 2004. Cancer networks subsequently developed costed action plans for taking forward the implementation of this guidance. All networks have been actively working towards its implementation since then. Monitoring of its implementation at network and Strategic Health Authority (SHA) level commenced in 2005, with full implementation due in December 2009. Monitoring will continue until this Local Delivery Plan target is fully implemented.

The guidance defined service models likely to ensure that patients with cancer, with their families and carers, receive support and care to help them cope with cancer and its treatment at all stages.

It set out 20 key recommendations on issues of importance to patients and carers. Some recommendations have required further national work to support local implementation. Most of the recommendations, however, require concerted action from cancer networks, commissioners, SHAs, provider organisations, multidisciplinary teams and individual practitioners. Some of the recommendations relate to

end of life care and are included under that section of this commissioning guidance. A prioritised list of recommendations (from the 20) has been developed by the National Cancer Action Team and network nurse directors. These recommendations were endorsed in the Cancer Reform Strategy.

The Living with Cancer section in the Cancer Reform Strategy builds on the recommendations within the NICE SPC Guidance and takes them further to incorporate patient survivorship.

Best practice guidance documents for commissioners commissioning supportive and palliative care services are:

- NICE SPC Guidance
- Manual for Cancer Services
- Integrated Cancer Care Programme 2004–2006 report, United Health Europe
- Holistic Common Assessment of Supportive and Palliative Care Need for Adults with Cancer – Assessment Guidance, National Cancer Action Team and King's College London
- Population Based Needs Assessment for Palliative and End of Life Care Services, National Council for Palliative Care.

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## 8.4 Key messages in the NICE Supportive and Palliative Care Guidance

The NICE SPC Guidance recommendations include the following:

- people affected by cancer should be involved in developing cancer services
- there should be good communication, and people affected by cancer should be involved in decision-making
- information should be available free of charge
- people affected by cancer should be offered a range of physical, emotional, spiritual and social support
- there should be services to help people living with the after-effects of cancer manage these for themselves
- people with advanced cancer should have access to a range of services to improve their quality of life
- there should be support for people dying from cancer
- the needs of the family and other carers of people with cancer should be met
- there should be a trained workforce to provide services.

### 8.4.1 Performance indicators

The key metrics/performance indicators taken from the NICE SPC Guidance to assist commissioners in procuring appropriate levels of service for their population are as follows:

- assessment and discussion of patients' needs for physical, social, spiritual and financial support should be undertaken at key points (such as at diagnosis, at commencement of treatment, during and at the end of treatment, at relapse and when death is approaching)
- 100% of patients should be given a record of their consultation
- specialist palliative care advice should be available on a 24 hours a day, 7 days a week basis (see End of life care)
- medical and nursing services should be available for patients with advanced cancer on a 24 hours a day, 7 days a week basis (see End of life care)
- access to rehabilitation equipment should be made available within 24 hours of the patient requiring end of life care (see End of life care).

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Key commissioning questions for supportive and palliative care	Where to find the answers
<b>Assessment</b>	
Can the service provider demonstrate use of supportive and palliative care assessment tools, assessing patients' needs at key points in the patient pathway?	Holistic Common Assessment of Supportive and Palliative Care Needs for Adults with Cancer – Assessment Guidance provides guidance
Can the service provider demonstrate effective communications systems for sharing the results of assessments within and across organisational boundaries?	Trust policy and audit examples
Can the service provider demonstrate a policy covering which staff will undertake assessment and that they have had appropriate training?	Trust training strategy/staff personal development plans
Can the service provider demonstrate that it has been able to provide/secure services to meet patient needs?	Local audit of needs assessment
<b>Co-ordination</b>	
Can the service provider demonstrate co-ordination of care as the patient moves through the pathway (e.g. case management, care tracker, key worker roles)?	Local trust systems policies



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Key commissioning questions for supportive and palliative care	Where to find the answers
Can the service provider demonstrate that there are inter-organisational, locally agreed policies for transferring patients between organisations as well as within them? Are these supported by explicit information requirements at the key stages of the pathway?	<ul style="list-style-type: none"><li>• Locally agreed inter-organisational policies in place</li><li>• Peer review assessment of implementation of key worker role</li><li>• CQuINS</li></ul>
Can the service provider demonstrate that the patient is given a clear point of contact at each stage of the pathway, both in and out of working hours?	Local policies/audit of patient notes
<b>Communications skills</b>	
Can the service provider demonstrate that all senior healthcare professionals in cancer have a level of competency in Advanced Communications Skills?  Does the network/SHA have a sufficient number of trained facilitators to meet provider training needs?	<ul style="list-style-type: none"><li>• Local provider training strategy</li><li>• Staff PDPs and follow-up of training</li><li>• Local record of senior healthcare professional attendance on the national Advanced Communications Skills Training (ACST) programme</li><li>• CQuINS – attendance on ACST course by appropriate core members of the multidisciplinary team (in future)</li><li>• Access to a range of communications skills training courses for all staff</li><li>• Local service provider complaints reports (relating to communications issues)</li></ul>

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Key commissioning questions for supportive and palliative care	Where to find the answers
<b>Psychological and rehabilitative support</b>	
Can the provider demonstrate that it has a range of supportive care services in place as per patient intake and need? (Bereavement, spiritual care, rehabilitation, psychology, complementary therapy.)	<ul style="list-style-type: none"><li>• Population Based Needs Assessment for Supportive and End of Life Care report</li><li>• Service level agreements with local mental health service providers</li><li>• Patient surveys</li></ul>
Does the provider have a workforce plan in place that underpins local service planning to ensure that it can maintain service levels for all services inclusive of rehabilitation and psychological services (e.g. four-level model for staffing, education and training, recruitment strategy, competencies).	<ul style="list-style-type: none"><li>• National Council for Palliative Care/National Workforce Review Team 2005 and 2007 Specialist Palliative Care Workforce Survey Reports</li><li>• Local provider workforce plans</li><li>• Knowledge and skills framework competencies</li><li>• Network service mapping reports of current service provision for both rehabilitation and psychology</li></ul>
What arrangements are in place between the health/ social and voluntary sectors to ensure that the needs of patients and families are met in a timely manner?	<ul style="list-style-type: none"><li>• Local service delivery plans</li><li>• Service level agreements</li></ul>
<b>Governance</b>	
Are there any quality issues identified in cancer peer review reports/trust self-assessments or clinical governance reports?	CQuINS, local quality reporting systems

## 8.5 Cancer Commissioning Toolkit metrics

The Cancer Commissioning Toolkit contains the following related metrics.

These can be found by accessing the corresponding chapter **Living with Cancer**, either via the dashboard or the content page.

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- compliance with patient experience measures
- specialist palliative care: percentage compliance with 3A measures
- network palliative care group percentage compliance with measures 1E-1.

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## 9. Commissioning end of life care

### 9.1 Background

The End of Life Care Strategy published in July 2008 set out the key priorities for improvement over the next 10 years and is focused on the care of adults above the age of 18:

'The aim of this strategy is to bring about a step change in access to high quality care for all people approaching the end of life. This should be irrespective of age, gender, ethnicity, religious belief, disability, sexual orientation, diagnosis or socioeconomic status. High quality care should be available wherever the person may be: at home, in a care home, in hospital, in a hospice or elsewhere. Implementation of this strategy should enhance choice, quality, equality and value for money.'

Driving up the quality and availability of end of life care that is responsive to patients' needs and choices is a key role for commissioners. A clear commissioning framework that is aligned to national quality standards and aims to deliver consistent end of life care pathways should be in place across all service providers of end of life care. This commissioning framework should include:

- the identification of the end of life phase
- the need for timely conversations about end of life care
- assessment and care-planning
- co-ordination and registration
- integrated service delivery
- review of care needs
- care for the last days of life
- care after death
- support and information for carers.

### 9.2 Key issues

#### 9.2.1 What is end of life care?

While the phase 'end of life' naturally ends in death, the definition of its beginning is variable, according to individual patient and professional perspectives. In some cases it may be the patient who first recognises its beginning. In other cases, the principal factor may be the judgement of the health/social care professional or team responsible for the care of the patient. In all cases, subject to patient consent, the beginning should be marked by a comprehensive assessment of supportive and palliative care needs.

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End of life care helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and the provision of psychological, social, spiritual and practical support (see Peter Tebbit, 2006).

This guidance for commissioners describes a whole-systems approach to end of life care that provides a high-quality, individualised service to meet the physical, emotional, spiritual and social needs of all people at the end of their lives, and their carers. It supports delivery of the End of Life Care Strategy and the end of life care policy set out in Building on the Best, Our health, our care, our say and High Quality Care For All that end of life services need to be commissioned to ensure that all people suffering from life-limiting illness are supported to enable them to have more choice over where they are cared for and where they die.

People frequently need care from multiple services, and they may need or want to transfer between locations (home, hospital, care home, hospice etc.). Co-ordination of care is often poor, however. People who are approaching the end of their life need access to care and

support 24 hours a day, 7 days a week. Services in the community are sometimes unable to respond to these needs, resulting in people being admitted to hospital rather than being cared for in their normal place of residence (home or care home). The evidence suggests that most, but not all, people would prefer *not* to die in a hospital; however, this is in fact where most people do die.

### 9.2.2 The end of life care pathway

The national End of Life Care Strategy sets out a nationally agreed generic pathway for end of life care services:

- Step 1 Discussions as the end of life approaches.
- Step 2 Assessment, care-planning and review.
- Step 3 Co-ordination of individual patient care.
- Step 4 Delivery of high-quality services in different settings.
- Step 5 Care in the last days of life.
- Step 6 Care after death.

These will be underpinned throughout by:

- spiritual care
- support for carers and families
- information for patients and carers.

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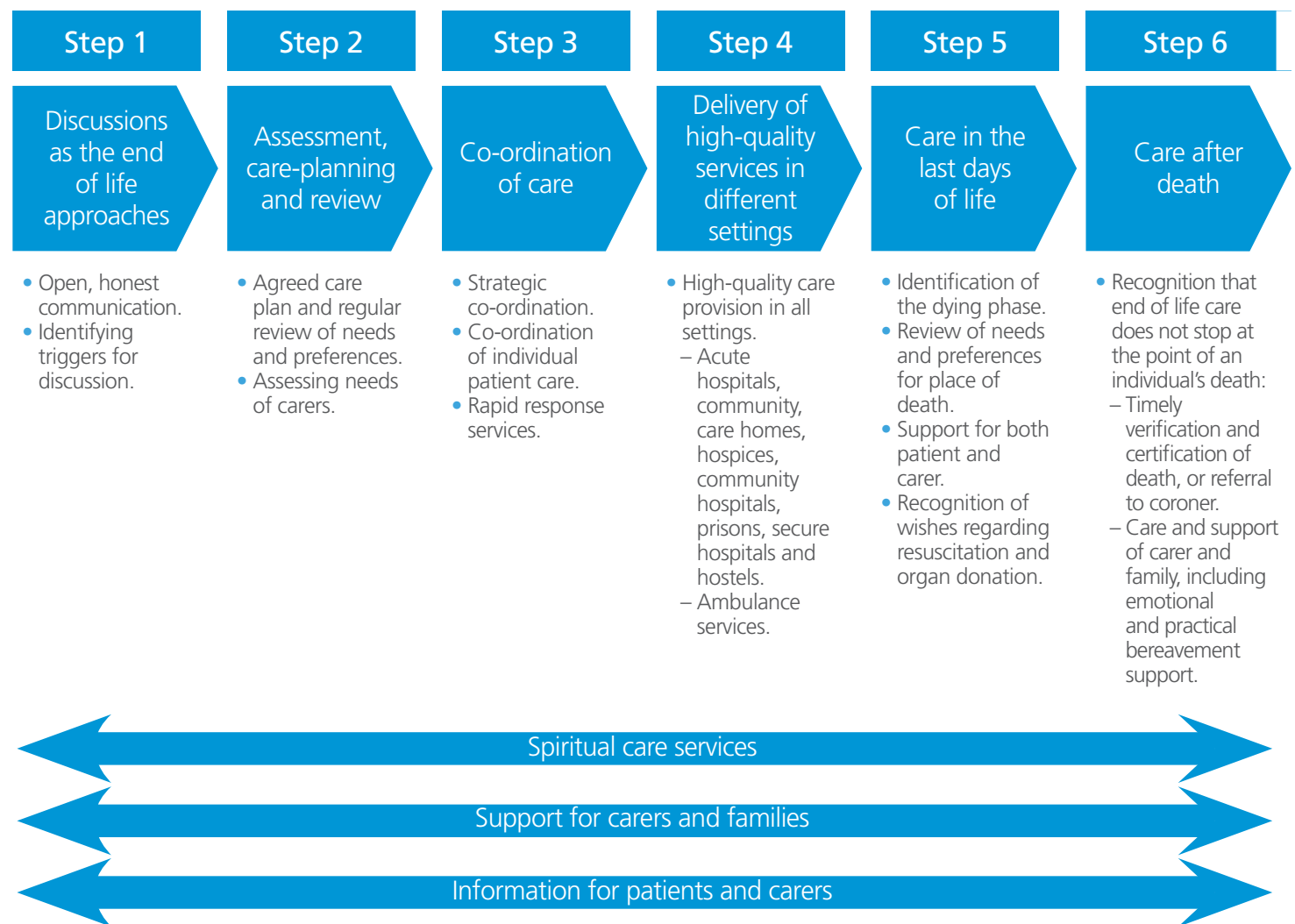
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### The end of life care pathway



Strategic commissioning and co-ordination is needed to support each of the above steps.

However, it is acknowledged that, locally, the detail will differ. No two people will have an identical end of life care pathway. For each individual, many different factors will affect their needs and preferences for care. These include:

- the nature of the condition or conditions from which they are suffering
- their social circumstances, for example whether they live alone or with others, close to family, in sheltered accommodation, in a care home or hostel, etc.
- deprivation and pre-existing vulnerabilities such as mental health and learning disabilities
- experiences of healthcare to date, particularly in relation to the deaths of others
- approach to life and psychological well-being
- cultural factors
- spiritual/religious beliefs.

Delivery of integrated services is an essential element in the end of life care pathway. Individual patients and their families/carers may need access to a complex combination of different services, including:

- primary care services
- equipment
- district nursing services
- occupational therapy
- personal social care services
- physiotherapy
- psychological support services
- day care
- acute medical services
- pharmacy
- specialist palliative care services
- financial advice
- out-of-hours services
- dietetics
- ambulance/transport services
- carer support services
- information services
- spiritual care
- respite care
- community and voluntary sector support
- speech and language therapy.

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Services need to be provided across a number of different settings: hospitals, care homes, hospices or in the community. On some occasions they will also be needed in other locations such as prisons and hostels for the homeless.

Primary Care Trusts (PCTs) may wish to identify funding to support the provision of end of life care from pooled budgets across health and social services, in order to support joint commissioning and investment across the whole pathway of care. Clear partnership arrangements with charities and other voluntary sector providers will be needed in order to ensure that the balance of resource investment is appropriate to ensure support across all areas.

### 9.2.3 What will good commissioning for end of life care look like?

At a national level, good commissioning of end of life care services will be achieved when the following, outlined in the End of Life Care Strategy, can be demonstrated:

- all patients approaching the end of life, and their carers:
  - have their physical, emotional, social and spiritual needs and preferences assessed by a professional or professionals with appropriate expertise

- have a care plan
- have their needs, preferences and care plan reviewed as their condition changes
- know that systems are in place to ensure that information about their needs and preferences can be accessed by all relevant health and social care staff
- all the services the person needs are effectively co-ordinated across sectors
- there is optimal delivery of care across all relevant services in hospitals, hospices, and care homes and in the community
- there is good quality care in the last days of life
- there are effective processes for the verification and certification of death, and care after death
- the quality and effectiveness of care can be robustly measured
- there is equality in access to and provision of end of life care services.

World Class Commissioning means that, locally, strategic plans will set out priorities and steps towards achieving the above.

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### 9.3. Commissioning and accountability relationships

The choice of commissioner of the service is for local determination. One of the local NHS organisations or the Local Authority may take on this role on behalf of all of the others. The responsible organisation could therefore be within the NHS or a Local Authority. It could also be providing some of the services while commissioning others.

#### 9.3.1 The lead commissioner

Where an organisation is interested in providing services to more than one commissioner, those commissioners might wish to work collaboratively with a single lead commissioner acting on behalf of all others in order to streamline the contracting arrangements. The commissioners would agree between themselves how to contract with that provider, but the provider will then be required to deal with only one commissioner.

There are also likely to be existing structures (groups/bodies/networks) that will already be commissioning related services, e.g. supportive or palliative care. It is important that whatever structures are in place, they ensure that there is good co-ordination across organisational boundaries and that they commission

end of life care services in accordance with the definition set out above. The terms of reference for existing commissioning groups may need to be adjusted to reflect this and their membership reviewed to ensure that it includes representatives from pharmacists, providers, trusts and community case managers, local authorities, out-of-hours providers, ambulance services and the voluntary sector.

All related services may be commissioned as a whole, but patients may move from a long-term conditions pathway (e.g. cancer requiring supportive care) to the end of life care pathway. It will therefore be important to establish the key triggers/criteria and decision-making regarding the beginning of the end of life care phase across the range of specialities including cancer, cardiac, respiratory, renal, neurological and dementia. It will also be important to consider both older people and older teenagers (i.e. in terms of transition to adult services) in planning end of life care services. Commissioners should be aware of the strategy set out in Better Care: Better Lives that addresses children's palliative care services.

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### 9.3.2 Strategic Health Authorities

Working in consultation/collaboration with PCTs and Local Authorities, Strategic Health Authorities (SHAs) will wish to determine whether strategic plans should be developed at single PCT level or by consortia of PCTs. Either way, they will want to ensure that local strategic plans cover the whole of their population. SHAs will wish to satisfy themselves that an inclusive approach has been taken in the development of local plans which:

- covers each step in the care pathway
- reflects the needs of the population and the local decisions about priorities based on the identified needs
- enables more patients to live and die in the place of their choice
- supports a shift in the balance of care from the acute sector to the community, with 24-hour medical and nursing services available to patients in all locations
- includes effective arrangements to co-ordinate individual patient care
- takes into account training and other workforce development requirements
- includes monitoring processes.

Workforce development will be one of the major cost-drivers for improving end of life care. SHAs will need to take into account additional workforce development needs arising from their local end of life care strategies when devising and monitoring their training and development plans.

### 9.3.3 Primary Care Trusts and Local Authorities

The World Class Commissioning programme identifies a vision for healthcare commissioning and what it will deliver: 'adding life to years, and years to life'. In the context of end of life care services, this means ensuring that individuals and their carers experience the highest quality of life during their end of life phase. World Class Commissioning positions Local Authorities and practice-based commissioners as key partners within PCTs. It is important that commissioners of end of life care services work collaboratively with key partners.

Currently, PCTs are usually responsible for commissioning end of life care services, working closely and in partnership with Local Authorities. Services should be commissioned against the agreed end of life care pathway. The pathway crosses a number of organisations and potential service providers, and it is therefore essential that commissioning and services are co-ordinated. Strategic co-ordination at the local level

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should be led by PCTs working in partnership with Local Authorities, and should involve close co-operation with all relevant service providers.

The Local Authority will provide a range of services that support people in their own homes, for example home helps, meals on wheels and assisted technology loans. Redesign of end of life care pathways could increase demand for such services, bringing additional resource implications. In addition, Local Authorities may need to adapt or reconsider existing provision of nursing home, respite care and social services support. Further work will be required in modelling capacity and demand for end of life care services across a community, and the use of personalised budgets should be considered. An understanding of the local population-based needs assessment and public health data may further support this. This will require PCTs and Local Authorities to work together to achieve improved health and well-being outcomes for their populations, and should be based on a sound Joint Strategic Needs Assessment (JSNA).

The JSNA will be the means by which PCTs and Local Authorities will identify the future health, care and well-being needs of local populations and will help to set the strategic direction of service delivery to meet those needs. Work on the JSNA will inform the local

Sustainable Communities strategy and will impact on priorities and targets in the local area agreement, which will be the main local service planning and delivery agreement.

### 9.3.4 Practice Based Commissioning

High Quality Care For All encourages practice-based commissioners (PBCs) to use NHS funds more flexibly in order to provide a better response to individuals' needs. PBCs are influential in developing services locally, both in influencing the commissioning discussion, as providers of services and as key contacts with users of services. PBCs should be represented on commissioning groups/boards and should sign up to the local strategic plan. One area where PBCs may have a key role is in supporting those approaching the end of their lives to remain at home if that is their wish. This could include rapid access to pharmacy and equipment services, emergency respite care, help with personal care, shopping and housework, bereavement care and support for carers, family members and close friends.

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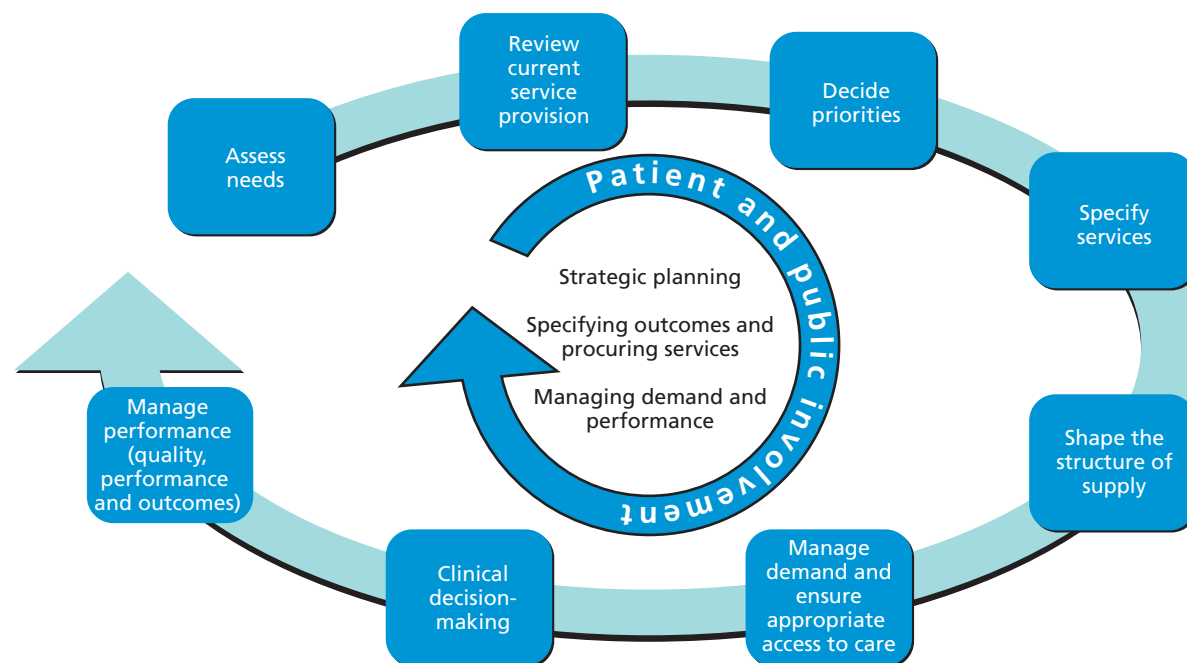
### 9.4 The commissioning process for end of life care

The overall purpose of World Class Commissioning is to contribute to the achievement of the goals of the health system. These are also reflected in the vision set out in the national strategy for end of life care services:

- good health outcomes
- high-quality and safe care
- good access

- responsive and patient-centred care
- equity and fairness
- contained costs
- efficient use of resources.

The diagram below outlines the process for commissioning world class end of life care services and is followed by a description of each step.



### 9.4.1 Patient and public involvement

The needs and wants of the public, patients and users should be at the heart of the commissioning process. Different kinds of users should be identified, together with the means to empower them. The patient voice should be embedded throughout the commissioning cycle at planning, tendering, choosing providers, procurement, monitoring performance and evaluation. A local strategy should be developed that addresses why, when, where and how to involve users in commissioning to ensure maximum value.

Capacity for user involvement should be built in by ensuring that:

- the system as a whole has capacity to respond to user views
- commissioners and providers have the capacity to carry out user involvement
- users have the capacity to get involved
- user and carer involvement is efficient and effective.

Where commissioners intend to make significant changes to a patient pathway, particularly where this involves moving services out of secondary care, public consultation is a necessary part of the commissioning process.

The commissioner should be aware of the demographics of the population, key influences upon public opinion and key local groups and individuals who should be actively managed through the consultation process. These might include local MPs, support groups, key players within the local voluntary sector and patient group leaders.

While it is important to record and understand the views of the public, world class commissioners also have a responsibility to market their intentions in a way that properly explains the broader advantages of a change in services to the community as a whole, and promotes any benefits of redesign – including financial benefits and those to individual patient experience. It is therefore imperative that a communications and publicity plan is drawn up in advance of the commencement of formal consultation.

### 9.4.2 Strategic planning

#### Step 1 – Assessment of needs

The Operating Framework for 2007/08 asked PCTs, working with Local Authorities, to conduct a baseline review of local end of life care services to support the implementation of the End of Life Care Strategy. Guidance for the review is set out in the Operating framework 2007/08: PCT baseline review of services for end of life care.

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The purpose of the review was to identify gaps in services and obtain a much clearer view of local need, in order to inform local commissioning activity. This was strengthened further in the Operating Framework for 2008/09, which stated that a key element of the End of Life Care Strategy will be to improve people's access to high-quality services, close to their homes, and that central to the delivery of this change will be the development of rapid-response services and co-ordination centres. The outline costs are mapped in the impact assessment for the national End of Life Care Strategy.

### Step 2 – Review current service provision

Local strategic plans will be guided by the outcome of JSNAs that all PCTs and Local Authorities have been required to produce since April 2008. Co-ordination is the key to developing a sound local strategic plan.

The end of life care pathway provided in the national End of Life Care Strategy provides a high-level generic pathway. This will need to be further developed at the local level, setting out the range of services provided at each step.

There are a number of national levers to support the redesign of end of life care pathways, including the following:

- End of Life Care Strategy (2008)
- High Quality Care For All (2008)
- Creating a Patient-led NHS: Delivering the NHS Improvement Plan (2005)
- Our health, our care, our say: a new direction for community services (2006)
- Commissioning framework for health and well-being (2007)
- Carers at the heart of 21st-century families and communities (2008)
- Gold Standards Framework, Liverpool Care Pathway of the Dying and Preferred Priorities for Care
- NHS Operating Framework 2009/10.

'Commissioners and providers debate and agree priorities, pathways and audit mechanisms. PBCs put forward effective alternative services. In reviewing services and re-designing pathways it will be important to ensure that the patients' care plan is owned and co-ordinated by a nominated person within the care pathway, and that the care plan is regularly reviewed and updated in partnership with the patient. In addition, the needs of the carer should be reviewed at regular intervals to negate the need for emergency admission of the patient due to carer breakdown.' Carers at the heart of 21st-century families and communities.

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End of life care services are complex. Service users and carers must be clear about the nature of this care and how the arrangements differ from other services, such as intermediate or continuing care. It should be clear (between the NHS, the Local Authority, the commissioner and the provider) from the outset who is responsible for meeting the cost of various elements of the overall end of life care pathway. This includes transport arrangements.

Some examples of service delivery models to be considered by commissioners can be found at: [www.endoflifecareforadults.nhs.uk](http://www.endoflifecareforadults.nhs.uk). Appendix A provides a generic end of life care service specification.

### Step 3 – Decide priorities

It will be important when in discussion with Local Authorities about JSNA priorities, and in discussions about spending priorities within PCTs, that costs and savings information is available to support cases for redesign where appropriate. The specific costs of end of life care services can be difficult to identify within the costs of care services in total. It is, however, possible to calculate the costs of under-occupancy of care home beds. Inappropriate admissions into services such as acute and intermediate care may need to be addressed through the pathway redesign for end of life care.

It is important that the views of users and carers and the outcomes of any surveys are taken into account in the

development of strategic plans. The following is a list of potential stakeholders who should be considered in the development of plans.

Services:

- ambulance/transport service
- primary care teams and services
- community nursing services
- intermediate care services
- social services
- older people's services (including those within the Local Authority)
- equipment
- occupational therapy
- psychological support services
- information services
- respite care
- speech and language therapy
- physiotherapy
- day care
- pharmacy
- financial advice
- dietetics
- carer support services
- bereavement support
- funeral directors
- coroners
- spiritual care/chaplaincy services
- medicines management
- acute sector services.

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Professionals:

- allied health professionals
- GPs
- secondary care clinicians
- clinical networks.

Providers:

- NHS palliative and specialist palliative care service providers, including NHS hospices
- care homes
- community hospitals
- emergency and urgent care services
- out-of-hours service providers
- prisons/hostels.

Third sector:

- charities/voluntary organisations, including hospices
- religious leaders
- support groups.

Users:

- expert patient/carer scheme.

Commissioners:

- HIV services commissioner
- long-term conditions commissioner
- mental health services commissioner.

Development of local strategies should take account of any new developments or influences and any expected changes in public attitudes and behaviour.

#### 9.4.3 Specifying outcomes and procuring services

The views of patients and the public should be taken into account when specifying the required outcomes from services commissioned from providers, as well as in the assessment and selection of providers bidding for contracts.

#### Step 4 – Specify services

When designing care pathways closer to home, it is also important to understand the financial implications for existing services such as those provided by the Local Authority and third sector organisations, as well as for medicines management and existing community services. All may need investment or redesign to support the new pathway for end of life care services.

#### Step 5 – Shape structure of supply

PCTs signal the strategic direction of end of life care services in the local prospectus and develop service specifications and support proposals as appropriate. They will need to work with NHS Trusts, Foundation Trusts, GP practices, neighbouring PCTs, private and third sector providers and Local Authorities to ensure that best services are commissioned for local people.

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Commissioners may choose to work collaboratively with the Local Authority and/or commissioners from other local PCTs in order to contract for services that represent value for money. The lead commissioner may negotiate on behalf of others, but all will need to sign up to contracts.

Commissioners should be clear about the services to be provided and the appropriate qualifications of staff and the standards to which the services should adhere. Schedules of anticipated activity should be included and actual activity monitored against these with providers at regular intervals. In addition, contracts should include details of key service performance indicators that represent clinical effectiveness, value for money and user satisfaction.

PCTs and Local Authorities should be mindful of the importance of the Compact on relations between government and the voluntary and community sector in England when commissioning with the voluntary sector. Any new services contracted from a voluntary sector organisation that are agreed as part of a local strategy should be paid for in full by the statutory sector. This ensures a 'level playing field' for all providers and fair and transparent commissioning and procurement.

#### 9.4.4 Managing demand and performance

Commissioners should monitor service level agreements (SLAs) and contracts with provider end of life care teams/GPs/multidisciplinary team (MDT) leads. Activity schedules should be included which will need to be monitored to assess uptake for services and the performance of providers. Modelling may need to be undertaken based on local population demographics.

##### **Step 6 – Managing demand and ensuring appropriate access to care**

Commissioners should establish strategies for care and resource utilisation to make sure that patients receive the right care in the right setting, ensuring that resources are used as effectively as possible.

##### **Step 7 – Clinical decision-making**

Working with social services and other agencies where appropriate, individual needs assessments should be carried out and patients and carers advised on the choices available.

##### **Step 8 – Manage performance (quality, performance and outcomes)**

Commissioners of end of life care services need to work to an agreed measurement framework aligned to the national end of life care quality markers, in order

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to monitor and assess the impact of investment and the outcomes achieved. Quality should be integral to all of the measures within the framework. The framework should be specific to each PCT and reflect the commissioned service model. It is suggested that the framework is based on five domains: patient experience, organisational, clinical, activity and resource utilisation.

Below are examples of how the metrics could be applied to end of life care services.

- **Patient experience**

As measured through carer and patient satisfaction, including meeting the cultural and religious needs of the population. Also measured by looking at the actual outcome for each patient compared with care plan intentions.

- **Organisational**

As measured through successful partnership working between acute trusts, PCTs, Hospice at Home, hospices, Local Authorities and nursing homes.

- **Clinical**

The new care pathway should result in fewer unexpected exacerbations and/or symptoms, and more planned interventions. Clinical audits of outcomes can be undertaken.

- **Activity**

If successful, the new care pathway should allow for fewer deaths in hospital with deaths instead taking place at home. In addition, there should be fewer emergency admissions of people at the end of their lives. Deaths within 14 days of admission to hospital should be significantly reduced. Audits can be undertaken of the spread of the three tools: the Liverpool Care Pathway (LCP), Preferred Priorities for Care (PPC) and the Gold Standards Framework (GSF).

- **Resources**

Measures should be identified that ensure value for money is obtained when commissioning effective services.

Local end of life care/palliative care teams monitor services against quality outcomes and report to commissioners and to their trust board. The PCT team assures quality by reviewing collective performance across the pathway and comparing the outcomes against any national audits. The PCT annual report/prospectus can be used to demonstrate progress to the public.

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### Key questions to ask about the SLA:

1. Is it a clear and concise written document explaining what the commissioner wants and what the provider can supply?
2. Does it detail the processes that will be used by both parties?
3. Is there a clear mechanism for measuring performance?

The following links may be useful to commissioners:

[CSIP Better Commissioning Programme](#)

[Achieving the competencies: Practical tips for NHS commissioners](#)

[World Class Commissioning](#)

### 9.4.5 Key questions that commissioners may wish to ask regarding end of life care

1. What mechanisms are in place to identify patients who require end of life care?
2. How do providers demonstrate that care is co-ordinated across boundaries?
3. What percentage of patients is cared for by an MDT?
4. What percentage of patients has a completed care plan identifying their preferred priorities for care?
5. What services are available in the community 24 hours a day, 7 days a week to enable people to live and die in the place of their choice? For example:

- nursing services including rapid response services
- single point of contact
- medical services
- personal care services
- access to pharmacy services and medicines out of hours
- access to equipment required in the home without delay.

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## 9.6 Other useful links

NHS End of Life Care Programme

National End of Life Care Strategy

Marie Curie Delivering Choice Programme

Liverpool Care Pathway of the Dying patient (LCP)

The Commissioning framework for health and well-being sets out the eight steps that health and social care should take in partnership in order to commission more effectively. It is aimed at commissioners and providers of services in health, social care and Local Authorities. It is part of the implementation of the White Paper Our health, our care, our say

NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000

Carers at the heart of 21st-century families and communities

## 9.7 Cancer Commissioning Toolkit metrics

The Cancer Commissioning Toolkit contains the following related metrics. These can be found by accessing the chapter **End of Life Care**, and the sections **Place of Death** and **Activity and Cost Related to End of Life**, either via the dashboard or the content page.

### Place of Death

- cancer deaths by place of death
- percentage of total cancer deaths by place of death
- cancer deaths by place of death, time trend.

### Activity and Cost Related to End of Life Care

- average hospital cost per patient, by PCT
- average hospital cost per patient, by SHA
- average number of bed days, by PCT
- average number of bed days, by SHA
- Intensive Therapy Unit (ITU) bed days, by PCT
- ITU bed days, by SHA.

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# Appendix A: Service specification for commissioning end of life care for social and health care commissioners

## Generic end of life care service specification

This is a broad framework for the delivery of joint health, social care, voluntary and independent sector end of life care services. It could also be used to negotiate the range of service to be provided by care homes. It recognises the importance both of medical and social models of care.

## 1. Description of the service to be jointly provided

The aim of the service is to improve end of life care for all, irrespective of diagnosis, and it seeks to provide greater choice for people in their place of care and death. This is underpinned by people having access to high-quality end of life care and being able to actively participate in decisions about where they wish to live and die.

Fundamental to this is early identification; assessment of need; implementation of an advance care plan; co-ordination of ongoing assessment; communication; and a co-ordinated multi-agency approach to care. Care must be provided by a competent, trained workforce.

## 2. National drivers

The outcomes have been informed by current national guidance:

- The End of Life Care Strategy (2008)
- High Quality Care For All (2008)
- Our health, our care, our say (2006)
- Our health, our care, our community (2006)
- NICE guidance on supportive and palliative care for cancer patients (2004)
- Mental Capacity Act (2005)
- Commissioning a patient-led NHS (2005)
- Standards for Better Health (2004)
- national minimum standards and supporting regulations
- National Service Framework for Older People
- National Service Framework for Renal Services Part 2
- Cancer Plan
- National Service Framework for Long-term Conditions
- Building on the best: Choice, Responsiveness and Equity in the NHS (2003)
- A New Ambition for Old Age (2006)
- National Stroke Strategy (2007).

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## 2.1 Outcomes

The desired outcomes of effective commissioning of end of life care include the following:

- individualised care:
  - people being treated as individuals and with dignity and respect, incorporating physical psychological social, practical and spiritual care needs
  - relatives and carers feel welcome and engaged in care
  - initial and ongoing assessment
- integrated organisational arrangements:
  - integration of health, housing and social care service delivery
  - use of integrated governance to promote safe care
- effective workforce planning, service reconfiguration and staff training and development
- reduction in the number of emergency admissions for acute care for those who have expressed a wish to die at home
- reduction in the number of people transferred from care homes to acute care in the last week of their life
- agreed patient transfer protocol for end of life care
- people receive improved palliative care services.

## 3. Places where services are to be provided

Care is provided in support of people's preferred choice where possible, and if this cannot be achieved the reasons are clearly stated and the next best option considered.

## 4. Environmental factors

- the environment is safe and clean
- providers should comply with the relevant standards as laid out by the Healthcare Commission and/or the Commission for Social Care Inspection and/or Patient Environmental Action Teams, and all other legislative requirements.

## 5. Duration

Individualised care plans should enable an individual to be supported 24 hours a day, 7 days a week.

## 6. Description of eligible service users

All adults nearing the end of life irrespective of diagnosis, in a defined locality of the service.

## 7. Service user access to services

- clear directory of services
- access to core services
- access to specialist palliative care services
- access to other relevant specialist services.

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## 8. Timing of referrals and access

- protocol for referrals to services
- agreed response time from referral for differing elements of palliative care services
- agreed criteria for access.

## 9. Explanation of how providers will seek to meet service users' needs

- methods for seeking people's views in planning and delivering services, and the outcomes
- single written plan signed up to by providers and the service user within agreed budgets.

## 10. Number of people who may be referred for access to the services and during what periods

Useful sources of information may include population-based needs assessments, Office for National Statistics and public health information to draw rough estimates of likely need for planning purposes.

## 11. Special delivery requirements

- an agreed care pathway has been developed for frontline staff, e.g. care workers, which includes support from other health and social care professionals, access to expert knowledge education and training

- the pathway should have explicit decision-making appropriate to the stage of the condition, including out-of-hours support from primary care to specialist palliative care, ambulance services and NHS Direct. This should be supported by locally agreed integrated policies and procedures
- there need to be clear protocols to support residential home staff in caring for people at the end of their lives to prevent them from being moved, e.g. access to nursing care
- in-reach clinical support and access to advice 24 hours a day, 7 days a week for care homes
- shared records across all care providers; single assessment should support this element
- evidence of the application of NICE guidance (palliative and supportive care) and all relevant national service frameworks
- consideration is given to the use of tele-care and tele-medicine.

## 12. Special equipment to be used

- core and specialist equipment is defined
- referral systems are clear
- delivery times for urgent and less urgent items are agreed
- schedules to include maintenance servicing and replacement
- out-of-hours is included for urgent items.

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### 13. Special personnel requirements

Access to specialist palliative care personnel for service users who don't have cancer.

### 14. Key performance indicators

Monitoring and evaluation of the joint commissioning agreement/service specification:

- evidence of joint health and social care commissioning
- evidence of clinical engagement in the commissioning process
- evidence of user involvement in the commissioning process
- evidence of attainment of the Standards for Better Health
- evidence of provider quality assurance processes
- definition of number of eligible service users
- evidence of actual numbers of service users who have accessed services
- evidence of numbers of service users with individualised care plans
- evidence of reduced numbers of emergency admissions
- evidence of roll-out of end of life tools in the locality\*
- evidence of patient safety measures/models, for example the care bundle approach
- audits, such as of admission rates to acute care, place of death, carer's survey.

\*The criteria for the roll-out of an end of life tool within a service are as follows:

GSF – that a register that identifies palliative care patients and a multidisciplinary meeting has been established;

LCP – that the pathway has been implemented; and

PPC – that the tool has been implemented.



## 10. Building for the future

### 10.1 Cancer research/audit

Cancer care is more knowledge-based than any other branch of healthcare. Comprehensive evidence-based guidance on the organisation of services has been published by the National Institute for Health and Clinical Excellence (NICE) and significantly informs the relevant sections of this guidance. Furthermore, a new series of clinical guidelines is being published by NICE to ensure the consistent delivery of evidence-based clinical treatment. An extensive range of technology appraisals is also available for cancer drug treatment. The search for new treatments continues, and the NHS has established a framework for the conduct of cancer research through the National Cancer Research Network (NCRN), which should have a close alignment with service delivery models in all networks.

The NCRN co-ordinating centre has set national targets for trial accrual and, more recently, for randomised controlled trial accrual. In general, patients benefit – both directly and indirectly – from inclusion in trials, but the opportunity for patients to be included in trials is unevenly distributed across the country, with local as well as national variations. Patients have a right to access appropriate clinical trials, but their clinicians do not always facilitate this.


Many research networks are dominated by oncology, and the service delivery model for chemotherapy dictates the accrual of patients. It is therefore sometimes difficult to map patient accrual into trials below network level. Research networks will routinely record the overall accrual of cancer patients into all studies and randomised trials in the National Cancer Research Institute (NCRI) portfolio. Commissioners should also inquire into the locations where trials are open and the distribution of recruitment. In addition they should inquire whether other (e.g. commercial) studies take precedence over NCRI studies in local portfolios.

Commissioners, working together at a cancer network level, should review the research performance of the network, taking into account the NCRI portfolio studies and other studies in their networks that are recruiting. They should seek a high level of recruitment, a broad portfolio of adopted studies (so that as many patients as possible have access to high-quality studies) and equal access across the geographical area of the network.

Network boards should take a strategic view of the development of cancer research in their area, building links with relevant universities to ensure the continued growth of knowledge about cancer, its causes, the opportunities for prevention, natural history and the effectiveness of treatments.

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Key commissioning questions for cancer research	Randomised controlled trials
What proportion of incident cancer cases is recruited onto NCRI portfolio studies?	Local NCRN
What proportion of cancer patients is recruited onto NCRI portfolio randomised trials?	Local NCRN
What is the distribution of patients recruited onto NCRI studies and randomised controlled trials, by trust and Primary Care Trust (PCT) of residence?	Local NCRN
How does local (trust and PCT) recruitment and network recruitment compare with national figures?	Local NCRN
Which trials are locally adopted, and why are any trials that are supported by the relevant multidisciplinary teams (MDTs) either not adopted locally or, if they have been adopted, not recruiting?	Local information from MDTs in the network site special group

## 10.2 Ensuring a strong cancer workforce

### 10.2.1 General considerations

Commissioning of future cancer services should take account of the demand for certain skills. With advances in technology and new ways of working it cannot be assumed that the current skill mix will be needed in the future. Short-term plans are limited by the current

workforce in place, but medium- and long-term service plans are key drivers for workforce change. Therefore, commissioners and providers need to ensure that the skills required will be in place, through effective education and training, commissioning and appropriate continuing professional development opportunities for staff.

In addition, workforce supply and demand issues need to be underpinned by effective management of workforce change with clear planning and effective engagement of key stakeholders across health and social care.

National Workforce Projects provide an extensive range of guidance, information and tools to support service commissioners and providers to achieve workforce change and improve support service planning. The NHS Next Stage Review documents A High Quality Workforce and Quality Workforce – Strategy Impact Assessment set out the workforce planning architecture, including education and training funding and commissioning, which supports planning for the cancer workforce.

### 10.2.2 Workforce plans

Commissioners should ensure that workforce plans contain the following considerations as a minimum:

- workforce issues are addressed as an integral part of service planning. Workforce can be a constraint on how services are delivered and issues need to be raised early enough in the planning process to enable alternative ways of delivering the services

to be considered. This could include new providers and new workforces

- underpinning policy drivers have been considered including the Next Stage Review, the Cancer Reform Strategy itself and other relevant areas, e.g. access targets, European working time directives, the impact of Payment by Results, Patient Choice
- external drivers have been considered, such as workforce demography, other labour market factors including the demand from the independent sector and the impact of technology/legal changes
- internal levers for change have been considered. These should be defined as concrete and measurable changes that have quantifiable outputs including:
  - new ways of working – skill mix, new roles, changed working practices
  - productivity gains – through technology and process improvement
  - skills development – enabling existing staff to take on enhanced roles
  - recruitment and retention initiatives – e.g. new sources of recruitment and Improving Working Lives initiatives

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- the impact of change in service provision on other healthcare areas and pathways across organisational boundaries has been considered. For example, the shift in services from secondary to primary care may have the following effects:
  - increased complexity of workload in secondary care as the easier cases are shifted to primary care. This may not result in a decrease in secondary care workload in proportion to the reduction in activity but will require higher levels of skills
  - additional workload in primary care draws in staff from other areas of primary care or secondary care and will require additional education and training to equip staff for new roles.

### 10.2.3 Key cancer workforce developments

Commissioners should be aware of the following developments:

- better use of skills. The appropriate transfer of tasks can free up the time of specialist staff who are in short supply, thereby helping to address critical skills shortages. The four-tier skill mix in therapeutic radiography is an example of this where greater use needs to be made of assistant practitioner

and advanced practitioner roles if the required increase in capacity of radiotherapy services is to be delivered

- new training initiatives – as a response to new technologies and NICE guidance, a training programme for laparoscopic surgery for colorectal cancer has been developed for surgeons and their teams, and commissioners should ensure that providers can offer the procedure to patients as an alternative to traditional surgery
- new roles – these can tap into new sources of supply and can sometimes address service delivery more effectively. These include: the development of dosimetrists in radiotherapy; clinical nurse specialists improving the delivery of information, support and care to patients; nurse endoscopists; and the Integrated Cancer Care Programme care tracker
- better team working. Well designed MDTs, where roles complement each other, will make the best use of skills and improve performance. Work is commencing to identify the characteristics of high-performing MDTs.

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## 11. Funding cancer services

### 11.1 Key issues

- cancer services cost the NHS around £4.35 billion a year (programme budgeting data 2006/07), most of which is spent on hospital services. This represents 5.2% of the NHS net operating cost
- cancer spend varies significantly across the country, with a two-fold variation in the spend per head of weighted population; but cost-effectiveness and outcomes should be the key considerations when assessing the appropriateness of current investment levels in cancer services
- cancer incidence in England is projected to increase by 25% over the next 15 years, mostly owing to the anticipated effects of population growth and ageing (Møller, H., Fairley, L., Coupland, V et al.), and therefore Primary Care Trusts (PCTs) will need to respond to increasing demands on cancer services and spend
- cancer drug costs have been growing at over £100 million per annum, and the Cancer Reform Strategy predicts that drug costs will continue to grow at a rate of approximately £60–80 million per annum
- in addition, some of the recommendations from the Cancer Reform Strategy will require significant additional investment by some PCTs if they are to be achieved; for example, only a few PCTs are

currently achieving the milestones for radiotherapy provision

- there are, however, also significant opportunities to save money and deliver better outcomes, freeing up resources for reinvestment in cancer care. In particular, inpatient costs offer significant opportunities for saving. Therefore PCTs need to consider carefully the opportunities for investment and disinvestment in their area in order to achieve the greatest benefit for the money available.

### 11.2 Background

With the growing pressures on cancer spend from increasing incidence, increasing drug costs and the recommendations of the Cancer Reform Strategy, the challenge facing PCTs is how best to meet the rising needs and demands for cancer care within a constrained budget. Cancer competes with other conditions for the limited budget available, and PCTs need to consider their priorities and assess their spend accordingly. It is vital that we maximise the effectiveness of our current spending. Doing so does not need to be at the expense of quality. There is good evidence that streamlined, less expensive services can deliver better outcomes. However, this still relies on good data and information on costs and benefits being available – which is far from the case in many instances. For cancer care, there are good cost-effectiveness

data on National Institute for Health and Clinical Excellence (NICE)-approved cancer drugs and on some new procedures, but there is a lack of such data on radiotherapy regimens, palliative care and established surgical procedures. This means that decisions based on cost-effectiveness are only possible in a limited number of areas. Wherever possible, this Cancer Commissioning Guidance seeks to identify the data that are available and that can assist in making such informed choices; where such data are not available, it offers some guiding principles.

### 11.3 Overall spend on cancer – programme budgeting data

Programme budgeting data provide a breakdown of total spend, by commissioner, into 23 programmes. The Cancer and Tumours programme has the third highest spend, at £4.35 billion, after Mental Health and Circulation Problems. Within Cancer and Tumours, the spend is broken down into the 10 sub-categories listed opposite.

Cancer sub-programmes	Total spend 2005/06 (£'000)
Head and Neck	146,391
Upper Gastro-intestinal	206,840
Lower Gastro-intestinal	326,166
Lung	204,413
Skin	96,500
Breast	403,807
Gynaecological	156,446
Urological	413,792
Haematological	470,869
Other	1,927,237
<b>Cancer and Tumours</b>	<b>4,352,462</b>

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The programme budgeting category Cancer and Tumours does not cover every element of NHS costs due to cancer, however. For example, it excludes GP visits by cancer patients, the cancer screening programmes (counted under Healthy Individuals) and other preventative work, such as stop smoking services. On the other hand, it does include some activity for benign tumours (such as gynaecological fibroids), which are unrelated to cancer services. Analysis by the Department of Health to identify spend on *cancer* (the definition and a summary of this work are given in Annex A) suggests that, on a national level, the overall spend on cancer in 2005/06 was £4.35 billion, which was within 1% of the 2005/06 programme budgeting figure for Cancer and Tumours.

Programme budgeting data provide some key benchmarking information for commissioners, such as the following (which are considered further below):

- percentage of overall spend that is on cancer
- spend on cancer per 100,000 standardised population
- percentage of overall cancer spend for each cancer sub-category.

### 11.3.1 Percentage of overall spend that is on cancer

By benchmarking a PCT's percentage of overall spend that is on cancer, it is possible to identify those PCTs that are apparently spending significantly more or significantly less than other PCTs on cancer as a share of their total budget.

PCTs will need to review their spend against their priorities and the relative burden of cancer in their population in relation to other needs, e.g. if they have a population with a particularly high need for mental health services (such as many London PCTs) or if they have high birth rates and so have high maternity costs. Therefore PCTs should also benchmark their spend in other programmes to identify any areas where they appear to be spending significantly more or significantly less than would be expected, given their priorities derived from the needs of their population.

### 11.3.2 Spend on cancer per 100,000 standardised population

Ideally, a PCT should aim to standardise its spend on cancer according to its population's relative need for cancer services. There are no methods currently developed, however, that standardise spend relative to cancer need specifically. Instead, the only options are:

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- spend per 100,000 population (unweighted)
- spend per 100,000 (unified weighted population).

The unweighted option is not recommended for benchmarking purposes, because the overall budget will be significantly affected by the age and gender profile of the population. The unified weighted population refers to the weighting that is applied to PCTs' populations when deciding their allocation of budget. This weighting is not disease specific, so does not fully adjust for the need for cancer spend.

There is no way to say what exactly *should* be spent on cancer, and, although this benchmark can identify low and high spenders per 100,000 unified weighted population, it does not by itself show whether the level of spending is entirely appropriate. A high spender may be very inefficient and so still be performing badly, whereas a low spender could be performing excellently, with good outcomes, and so there may be no need for additional investment. Therefore it is important to look at other indicators of service quality and health outcomes.

### 11.3.3 Percentage of overall cancer spend for each cancer sub-category

This is helpful information for commissioners as they seek to identify relatively high or low spend by cancer type. Ideally, these data would be standardised to the incidence of the cancer in question, and future versions of the Cancer Commissioning Toolkit may allow this. In the meantime, however, PCTs will need to bear in mind their incidence of individual cancers when considering their position on this measure. In addition, these data were collected for the first time in 2006/07, so the first year of data may still be prone to some inaccuracies.

### 11.3.4 Where are programme budgeting data available?

Programme budgeting data are available in three separate places:

- the Cancer Commissioning Toolkit, which benchmarks programme budgeting data in a number of ways and also provides a methodology for separating it into components of care

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- the DH National Programme Budget project homepage, which includes spreadsheets of the full data by PCT, SHA and cancer network
- the National Centre for Health Outcomes Development (NCHOD) website, which contains an interactive atlas where users can compare both PCTs' spend and outcomes.

#### 11.4 Comparing spend with outcomes

The NCHOD atlas allows PCTs to see where they fall in an xy-scatter graph of both spend on cancer and cancer outcomes. If a PCT is a particularly low spender on cancer and has poor health outcomes, this indicates that it may be spending too little on cancer and that it should investigate further where more investment may be appropriate. If a PCT is a particularly high spender on cancer but still has poor outcomes, it needs to consider where money is currently being spent that could be redeployed, in evidence-based interventions, to achieve a greater health benefit for its population. PCTs with relatively good health outcomes, though, should consider if there is still scope to improve their health outcomes – either through more efficient use of the resources already being spent on cancer, or through additional investment.

Relying solely on this data source for the rationale for investment and disinvestment, however, is not recommended, as various studies have shown that there is no simple relationship between spend and outcomes. For example, a 1996 McKinsey report on healthcare productivity, which compared the US, Germany and the UK, found that higher spend does not mean better health outcomes. Health outcomes are affected by many factors, including lifestyle, timeliness of treatment and other factors that are not necessarily reflected in overall spend. In addition, inefficiencies can increase spend and decrease quality of services, so spend is increased but health outcomes are negatively affected. There is also a delay in seeing the benefits of some investments, for example on preventative work.

#### 11.5 Redistribution of funds within cancer spend

Within the overall envelope of spend on cancer, there may be opportunities to redistribute funds to achieve greater benefits for the money available. The following section provides some specific examples and identifies the evidence for investment and disinvestment at a national level; but PCTs need to evaluate their own data to identify where improvements can be made.

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### 11.5.1 Inpatient care

The Cancer Reform Strategy highlighted the importance of the Inpatient Management Programme (see Treatment services), which should achieve significant savings for the NHS on secondary care (in the order of £270 million per annum), while improving the care that cancer patients receive (see also the Cancer Reform Strategy impact assessment).

The Cancer Commissioning Toolkit includes a section within the 'Funding Cancer Care' module on 'Activity and Costs'. Here, commissioners can benchmark their activity by admission type, specialty and/or cancer site, and can identify the costs associated with this activity and the trusts in which the activity is undertaken. In this way, PCTs are able to identify any specific areas to target for potential efficiency gains.

#### *Preventative and early detection interventions*

There is good evidence on the very favourable cost-effectiveness of preventative interventions (such as stop-smoking services and the breast, bowel and cervical screening programmes). PCTs should ensure that they are maximising the potential reach of such interventions.

### 11.5.2 Drug spend

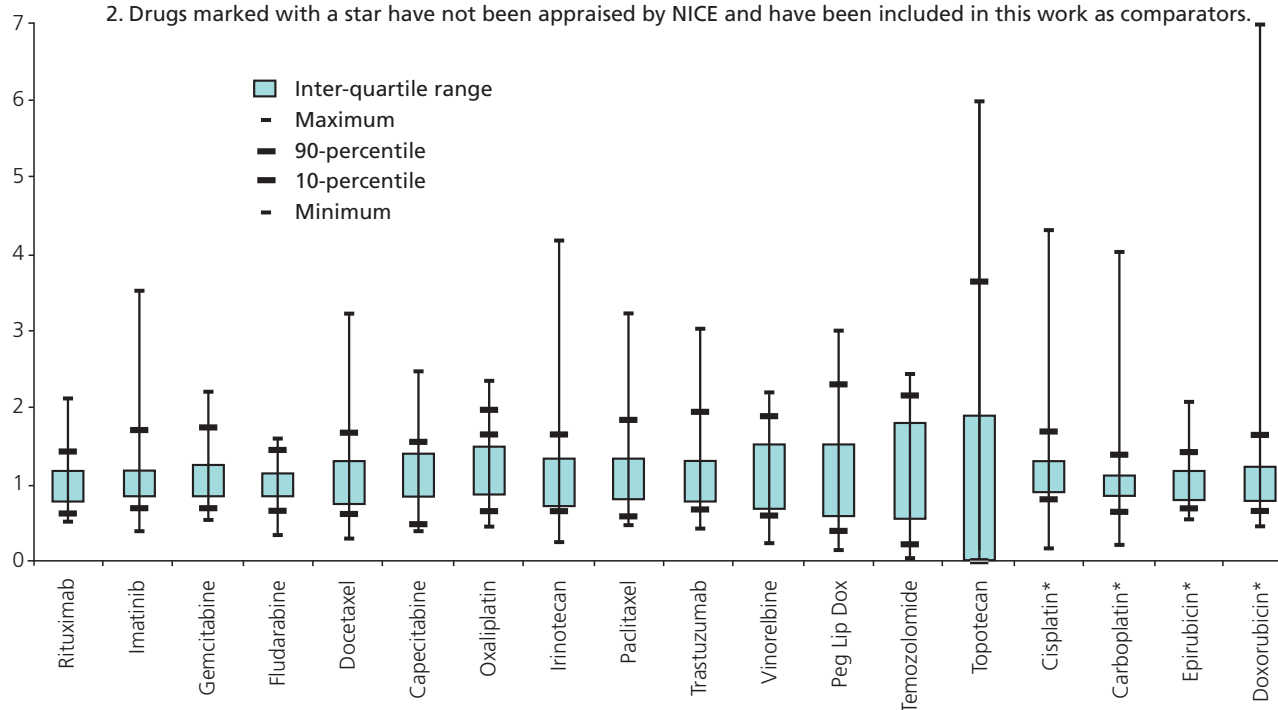
Drug spend is a key cost pressure, owing to the rate of increase of the cancer drugs budget as new drugs become available. Rather than look at overall spend, it may be more helpful to analyse the uptake of individual cancer drugs. Figure 11.1 on the next page comes from a report on NICE-approved cancer drug usage for the National Cancer Director, an analysis which will be repeated during 2008/09. The 2005 data show considerable variation in uptake of individual drugs from one cancer network to another. However, even with this level of information, interpretation remains difficult since such data are often difficult to fully adjust for need; and there is often no good objective measure of what the right level of provision should be.

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Figure 11.1: Variation in uptake of NICE-approved drugs between cancer networks

Distribution of drugs used per thousand population across cancer networks (Jan to Jun 2005), scaled so that median value is 1

Notes: 1. Raltitrexed, Topotecan and Uracil/Tegafur have been excluded as their low usage gives a 10 percentile value of zero.  
 2. Drugs marked with a star have not been appraised by NICE and have been included in this work as comparators.



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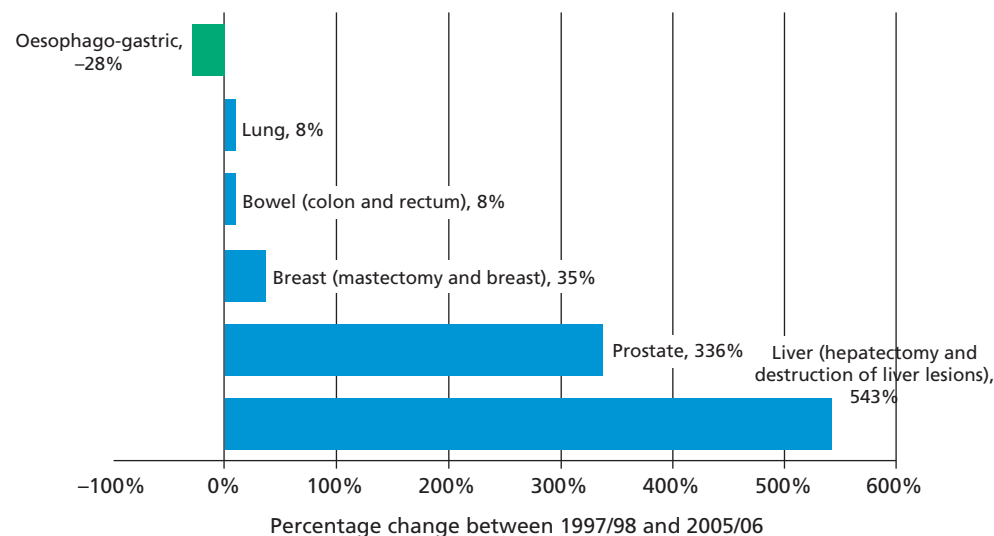
### 11.5.3 Radiotherapy

If the Cancer Reform Strategy's recommendations on radiotherapy are to be achieved, then significant investment is required in terms of equipment and workforce. There are also opportunities for some PCTs to make the services they commission more efficient – by, for example, running linear accelerators for longer hours and on bank holidays, thus getting the most out of the available equipment. The impact assessment that was published along with the Cancer Reform Strategy details the national cost impact of this.

### 11.5.4 Surgery

Surgery cures more patients of cancer than any other intervention, and has been the mainstay of treatment for many types of cancer over many years. Overall demand for cancer surgery is likely to rise, based on current trends, although the pattern does vary between cancer types. Figure 11.2 below shows trends in activity related to different types of surgery, based on data from Hospital Episode Statistics.

Figure 11.2: Changes in surgery activity related to cancer



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### 11.5.5 Other areas

PCTs need to make decisions based on a number of factors, and while ideally costs and benefits would be quantified to inform such decisions, in reality the necessary information may not be available. Therefore PCTs need to decide on the basis of a range of other information and lessons learned from other areas.

The table below provides some possible areas for investment and disinvestment that PCTs may wish to consider in relation to funding cancer care.

### 11.6 Information sources

Commissioners should make as much use as possible of the information available to help them as they decide on resourcing levels. Programme budgeting data give spend by condition and by cancer type, as was discussed earlier. NHS reference costs and Healthcare

Resource Group (HRG) tariffs also provide key cost and activity data, which can be used to break down total spend into its constituent parts. This is covered further in Annex A. When HRG Version 4 is introduced, this will give even richer data on cancer spend.

### 11.7 Key questions for SHA/network/PCT/ Local Authority

- how much do you currently spend on cancer services?
- how is this distributed across the different cancer treatments and support services?
- are you a relatively high or low spender on cancer services per 100,000 (unified weighted) population?
- does this level of spend accurately reflect the level of priority that cancer should receive, relative to competing conditions and the various needs of the local population?

Things to do more of (= investment)	Things to do less of (= disinvestment)
<ul style="list-style-type: none"> <li>• Better access to diagnostics where appropriate</li> <li>• Screening and early diagnosis</li> <li>• Alternative, more cost-effective, places of delivery</li> <li>• Smoking cessation and lifestyle interventions</li> <li>• Targeting health inequalities</li> <li>• Earlier NICE approval of cost-effective interventions</li> <li>• Supported discharge</li> </ul>	<ul style="list-style-type: none"> <li>• Unnecessary use of hospital beds</li> <li>• Avoidable accident and emergency (A&amp;E) admissions</li> <li>• Nth line chemotherapy for patients with a poor prognosis</li> <li>• Ineffective care</li> <li>• Overuse of treatments near end of life</li> <li>• Poor asset productivity (e.g. linacs)</li> </ul>

- how do your cancer outcomes compare with your relative spend? Are you a high spender and high achiever, low spender and low achiever; a low spender and high achiever (the ideal!) or (the worst case) a high spender and low achiever?
- where could you invest to achieve maximum additional health benefits?
- where could you disinvest without reducing benefits (for example, through the Transforming Inpatient Care Programme)?

### 11.8 Cancer Commissioning Toolkit metrics

The Cancer Commissioning Toolkit contains the following related metrics. These can be found by accessing the corresponding chapter **Funding Cancer Care** and sections **Activity and Cost** and **Programme Budgeting**, either via the dashboard or content index.

#### Activity and Cost

- costs per FCE by cancer type
- activity and cost by cancer type
- total cost by cancer type
- activity (FCEs) per 100k unified weighted population
- costs per 100k unified weighted population
- normalised activity (FCEs) per 100k population: trend analysis.

#### Programme Budgeting

- share of cancer spend trend
- cancer spend breakdown by type
- trend of actual cancer spend per 100k unified weighted population
- benchmark of cancer spend per 100k unified weighted population.

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## Annex A – A guide to undertaking an analysis of Primary Care Trust spend on cancer

### A1 Introduction

This annex seeks to help commissioners to analyse their spend on cancer, and hence to identify potential areas for more investment, for disinvestment and for efficiency improvements. There is a range of data sources available, and a number of options on how to go about analysing spend on cancer. This annex aims:

- to demonstrate a 'bottom-up' calculation of the spend on NHS cancer services by cost area in England (2005/06 estimate). This was undertaken by Department of Health analysts and published in the Cancer Reform Strategy (p. 119)
- to compare this estimate with programme budgeting data and clarify differences and agreements
- to consider how Primary Care Trusts (PCTs) may replicate this analysis to obtain a breakdown of their own spend on cancer services.

### A2 Key data sources

The 'bottom-up' calculation presented in this document uses the following key data sources for most of its cost estimates.

### A2.1 Hospital Episode Statistics – admitted patient data

Hospital Episode Statistics (HES) provide detailed data on every patient admitted in England. For each episode of care, there is information available, such as diagnosis codes, procedure codes and length of stay. This allows us to identify cancer activity and, by linking with NHS reference costs, to estimate the costs associated with it.

### A2.2 NHS reference costs

The National Schedule of Reference Costs 2005/06 for NHS Trusts and PCTs combined gives details on how (and on what) over £36 billion of NHS expenditure was used in England in the 2005/06 financial year. It includes a breakdown of hospital admissions costs, outpatient costs, hospital radiotherapy and chemotherapy costs, and other primary and secondary care provision. Commissioners should have access to their local organisations' submissions to the national schedule, which they could use to obtain local activity and costs. Note that this document presents an estimate for 2005/06 costs, and that all the figures are in 2005/06 prices.

### A3 Bottom-up calculation of spend on cancer services in the NHS by cost area in England

Table 1 on the next page gives a summary of the cost estimates for England by cost area for 2005/06. The methodology and estimates used to derive this estimate follow.

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**Table 1: Estimate of the costs of NHS cancer care in 2005/06**

Cost element (2005/06)	Estimated cost (£m)
1 Primary care costs:	
1a GP visits for cancer diagnosis and treatment	104
1b Cancer screening programmes	225
1c Spend on cancer drugs prescribed in primary care setting	211
2 Outpatient care costs:	
2a First and follow-up outpatient appointments relating to diagnosis of cancer	60
2b First and follow-up outpatient appointments relating to treatment of cancer	282
3 Hospital treatment costs:	
3a Hospital admissions with a primary diagnosis of cancer	2,415
3b Chemotherapy treatment costs	330
3c Radiotherapy treatment costs	205
3d Accident and emergency (A&E) attendances for cancer patients	115
4 Other costs	
4a Specialist palliative care costs	200
4b Other costs	210
<b>Total</b>	<b>4,357</b>

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## A4 Methodology and estimates

### 1a GP visits for cancer diagnosis and treatment

Data from the General Practitioner Weekly Returns database (Birmingham Research Unit, Weekly Returns Service, Annual Report 2003) suggests an estimated average of 619 visits related to neoplasms per 10,000 population per year. This equates to a cost of approximately £104 million per annum.

### 1b Cancer screening programmes

National figures suggest that £225 million is spent on breast and cervical cancer screening programmes annually (source: Department of Health). It is further estimated that, when fully rolled out, the bowel screening programme will cost £60 million per annum, so this can also be factored into future years' estimates.

### 1c Spend on cancer drugs prescribed in the primary care setting

Prescriptions and pharmacy statistics (PPS) enable us to break down NHS spend on cancer drugs in the community. The total cost of cancer drugs prescribed in the community has been estimated at £211 million (October 2005 to September 2006), the bulk of which (90%) goes on endocrine drugs.

### 2a First and follow-up outpatient appointments relating to diagnosis of cancer

NHS reference costs for 2005/06 provide activity and cost estimates for the following procedures performed in an outpatient setting:

- fine-needle biopsy of breast
- needle biopsy of prostate
- biopsy of cervix uteri
- rigid sigmoidoscopy
- colposcopy
- bronchoscopy
- diagnostic endoscopic examination of larynx
- diagnostic endoscopic examination of pharynx.

These totalled £60 million. (This assumes that all of these tests are attributable to cancer, as it is not possible from the data to distinguish the reason for diagnosis.) Although this is likely to be an overestimate, there will also be many other types of assessments for cancer (including, for example, MRI and CT scans) which have not been included here because the data are not available to distinguish the reason for diagnosis. While this figure may be inaccurate for these reasons, it is currently the best estimate possible based on the available data.

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## 2b First and follow-up outpatient appointments relating to treatment of cancer

NHS reference costs for 2005/06 provide activity and cost estimates for the following outpatient specialties:

- clinical oncology
- medical oncology
- gynaecological oncology
- radiotherapy (consultation only)
- chemotherapy (consultation only).

These totalled £203 million.

In addition, it was assumed that there are two outpatient appointments (i.e. one 'new' and one 'follow-up') for each cancer patient undergoing surgery. This can be confirmed by looking at HES data for elective admissions with a cancer diagnosis under a surgical specialty. This totalled £79 million. The total cost of all this activity was £282 million.

## 3a Hospital admissions with a primary diagnosis of cancer

HES 2005/06 data were used to identify cancer admissions as defined below, and were linked to NHS reference costs for 2005/06 to calculate the cost of this activity.

### *Definition of a cancer admission*

We defined a cancer admission as one with an appropriate cancer diagnosis in any of the first three diagnosis fields. An appropriate cancer diagnosis was any malignant, in-situ or uncertain neoplasm, or a benign tumour in a neurological site.

### *Linkage with NHS reference costs for 2005/06*

The costs of the inpatient episodes were estimated using the NHS National Reference Cost Schedule 2005/06, which gives average cost figures for the country. Individual episodes recorded on HES have three key data fields, which are used to identify the correct cost of that episode: HRG, admission type and length of stay. A cost per episode can be identified, plus any additional costs for excess bed days. In addition, the Augmented Care Periods for bed days in intensive care or high dependency units can be identified and multiplied by the weighted average cost per bed day, also available within the NHS reference costs.

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#### *Further breakdown of admissions*

In order to separate out the costs of surgery, it is possible to identify episodes in which a therapeutic procedure was undertaken. It is also possible to separate out admissions for chemotherapy, which may be identified using HRG codes ending in '98', e.g. C98 Chemotherapy with a Mouth, Head, Neck or Ear Primary Diagnosis. It is then possible to separate out the remaining admissions into day case and inpatient and elective and non-elective using the 'admission type' field. The results, in terms of total costs at a national level, are given opposite.

Cost element	Cost £m
Surgery treatment costs	628
Day-case chemotherapy (excl. drug costs)	139
Inpatient chemotherapy (excl. drug costs)	135
Other day cases	247
Other elective inpatient costs	321
Other non-elective inpatient costs	824
Critical care costs	120
<b>Total</b>	<b>2,415</b>

Note: 2005/06 prices.

#### **3b Chemotherapy costs**

NHS reference costs for 2005/06 have a separate category for chemotherapy costs, which reflects just the drug component of costs, regardless of the setting in which it is administered (inpatient, day case or outpatient). This is separate from the costs within the inpatient or outpatient costs already outlined. In 2005/06 it was £330 million.

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### 3c Radiotherapy costs

NHS reference costs for 2005/06 have a separate category for radiotherapy costs, which reflects just the costs of the radiotherapy department, regardless of the setting in which treatment is administered (inpatient, day case or outpatient). This is separate from the costs within the inpatient or outpatient costs already outlined. In 2005/06 it was £205 million.

### 3d Accident and emergency (A&E) attendances for cancer patients

NHS reference costs for 2005/06 have accident and emergency (A&E) activity and costs, including for minor injury units, but these data are not broken down by diagnosis. It may therefore be assumed that cancer accounts for 9% of this activity, which is the proportion of overall emergency hospital admissions that is related to cancer (using the definition of a cancer diagnosis specified in 3a above). It equates to £115 million nationally.

### 4a Specialist palliative care costs

The National Council for Palliative Care estimates that the cost of specialist palliative care is in the region of £200 million for England. Some other estimates suggest a slightly higher figure, but as palliative care is not exclusively for cancer patients, the cost of specialist palliative care can be taken to be a reasonable estimate for the cancer element of the costs.

### 4b Other costs

NHS reference costs for 2005/06 have a number of other categories of costs that will be incurred in relation to cancer. As a further breakdown of these costs by patient diagnosis is not available, it is not possible to identify the cancer element of the costs, so the proportions need to be estimated. These are given in the table on the next page.

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**Table 2: Breakdown of 'other costs'**

Element of 'other costs'	Percentage of costs due to cancer	Rationale
Community/outreach specialist nursing services, bands 1 and 2	95%	Bands 1 and 2 are 'Cancer' and 'Palliative/ respite care'
Bone marrow transplant episode	94%	Percentage taken from British Society of Blood and Marrow Transplantation registry data 2006
Direct access: radiology services test	12%	Assumed to be in proportion to all admissions, of which cancer is 12%
Observation/pre-admission/medical admissions unit	9%	Assumed to be in proportion to all emergency admissions, of which cancer is 9%
Paramedic services provided by rural and urban teams	6%	Estimate is less than the 9% of emergency admissions that are for cancer because certain other conditions will be more time-critical than cancer
Community therapy services	3%	Low estimate for elements of costs where cancer was likely to take a low proportion
Direct access: pathology services test	3%	
Rehabilitation services	3%	
Community nursing services	3%	

These totalled £210 million nationally.

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### A5 Comparison with programme budgeting data

The National Programme Budget (PB) project provides a retrospective appraisal of NHS resources, broken down into programmes. One programme is Cancer and Tumours. The total figures agree well with the bottom-up estimate outlined in this document (for 2005/06 the figure was £4,302 million, so it was within 1% agreement), but there are key differences in what is included in each analysis of spend, and these render the comparison not 'like for like'.

### A6 How to undertake PCT estimates

PCTs may wish to undertake a similar analysis of the breakdown of cancer spend in their own area. The methodology presented here for creating a national estimate can generally be replicated at a local level, using local information, to reflect the local spend. It is also possible to short-cut some of this work using tools that are available and alternative estimates of some cost elements. There is more detail on this on the next page.

Factors excluded from PB data but included in bottom-up estimate	Factors included in PB data but excluded from bottom-up estimate
<b>GP visits</b> In PB data, these are included in the programme General Medical Services/Personal Medical Services	<b>Benign tumours excl. neurological ones</b> PB data include benign tumours, which in particular will attract significant costs in hospital inpatient activity
<b>Cancer screening programmes</b> In PB data, these are included in the programme Healthy Individuals	Possible areas not identified in the bottom-up estimate include: imaging activity, outpatient activity relating to diagnosis of cancer not in oncology specialties, general palliative care
<b>Admissions with a secondary diagnosis of cancer but a non-cancer primary diagnosis</b> These may be counted against a number of PB categories for other conditions	

### A6.1 Local data

NHS reference costs returns are available by organisation, so a PCT can use the returns from the main acute trusts, as well as its own return. It can also use the organisations' Patient Administration System (PAS) data to identify the admitted patient activity. These two information sources will allow a PCT to estimate most of the cost elements.

### A6.2 Tools and alternative sources

The Cancer Commissioning Toolkit provides cost estimates for inpatient activity by PCT and cancer network, according to the definitions and methodology provided here.

The National Programme Budget data will provide an estimate of total spend on cancer, and of this, the amount spent on cancer drugs. This estimate of spend on cancer drugs is a helpful alternative source for the costs of chemotherapy and primary care cancer drugs in this annex. However, it may not agree exactly with the estimates in this annex, as the sources differ. The estimate of total spend on cancer is a helpful benchmark for PCTs and is included in the Cancer Commissioning Toolkit, but the differences in definition described above should be noted.

### A6.3 Remaining areas

There are some areas for which a local estimate of spend will not be possible based on these sources, particularly general practice costs. PCTs will need to use other data available to them in order to create a locally adjusted estimate of this cost.

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