

Ensuring effective commissioning of cancer services: A survey of GPs

Effective commissioning of cancer services will be essential if outcomes for cancer patients are to continue improving across the country. Planned reforms to the NHS will radically change the way that services for cancer patients are commissioned, and the Cancer Campaigning Group (CCG) believes that the plans to create a multi-level system of commissioning presents both challenges and opportunities. Getting cancer commissioning right will be central to achieving the Government's goal to save an additional 5,000 lives every year by 2014/15.

The CCG has therefore undertaken research into the commissioning of cancer services, and the support that will need to be put in place to enable commissioners to provide the best possible care. This research, alongside the views and experiences of our members, has enabled us to make five key recommendations for the shape of cancer commissioning. These findings and recommendations are set out below.

Our survey of GPs found that:

- Most GPs (71%) agree or strongly agree that they will require specialist advice to effectively commission cancer services
- 82% of GPs agree or strongly agree that GPs in their area with responsibility for commissioning will need specialist advice
- Most GPs believe that radiotherapy (81%), cancer surgery (79%) and chemotherapy (76%) should be commissioned at a regional or national level
- The majority of GPs (59%) believe that post-treatment support for cancer patients should be commissioned locally
- These findings are broadly consistent across GPs in urban and rural areas
- There is notable regional variation in the level of support that GPs believe they will require to effectively commission cancer services. Only 56% of GPs in NHS South East believed that they would need support to commission cancer services, compared to 76% in NHS North East and NHS East Midlands and 77% in NHS London

Given the consensus identified among GPs that specialist support and some regional and national commissioning of services will be necessary, the CCG is calling for:

1. The Department of Health to ensure that cancer networks are properly funded until at least 2014 when GP commissioning consortia are fully bedded-in. We also look to the NHS Commissioning Board to ensure that the expertise currently held in cancer networks is retained for the longer term
2. The NHS Commissioning Board should commit to engaging in a robust consultation with the cancer community when developing the details of how effective cancer commissioning will be achieved. For some care it is appropriate that this should be commissioned at a regional or national level and GP consortia should be supported to commission collaboratively when appropriate. In order to commission high quality patient care, it is essential that there is integration and communication across the whole care pathway, including primary, secondary and tertiary care

3. GP consortia to be supported in the commissioning of cancer services by increased routine collection and timely publication of data from the national cancer data repository by 2013, particularly on cancer staging (including for advanced cancers), and more swift publication of data on cancer incidence, survival and mortality. This will help improve the planning and development of cancer services
4. Commissioners to be incentivised to ensure high quality cancer services, with indicators in the Commissioning Outcomes Framework incorporating rarer as well as more common cancers and measures of patient experience
5. GP commissioners to be encouraged to consider how they can effectively involve people affected by cancer in reviewing and designing services

Background

Improving Outcomes: A Strategy for Cancer notes that 'commissioning of cancer services has historically been variable'¹. Cancer services have traditionally been largely commissioned by primary care trusts (PCTs), with a number of services for both common and rarer cancers being commissioned by NHS Specialised Services². Many PCTs have been supported in their commissioning by cancer networks. Cancer networks bring together service providers and commissioners to work collaboratively to plan and deliver high quality cancer services. They undertake a number of roles, including provision of specialist commissioning expertise and advice on cancer services, guidance on how specialist cancer services should be commissioned and support in developing cancer user involvement mechanisms.

The Coalition Government reforms to the NHS will fundamentally change the commissioning of cancer services. While many of the reforms proposed are already underway, such as the development of pathfinder GP consortia and the creation of health and wellbeing boards, there remain a number of important questions when considering the future commissioning arrangements for cancer services. These include the support that will be available to GP commissioning consortia, and the level at which different services will be commissioned. Cancer networks have played a central role in the commissioning of cancer services. A commitment has been made for the funding of cancer networks in 2011/12³, but their future beyond that date is still to be decided.

There has been much debate about the readiness of GP consortia to take on different areas of commissioning responsibility. In a BBC poll conducted by ComRes in 2010, 53% of GPs felt that they were not prepared to commission cancer services⁴. A survey by nfp synergy found that only 8% of GPs have a specialism or particular interest in cancer, compared with 25% for diabetes and 16% for mental health⁵. While clinical leadership in commissioning services is welcome, and will improve outcomes in some areas, the CCG is keen to ensure that GP commissioners are ready and supported to take on this key responsibility in cancer services.

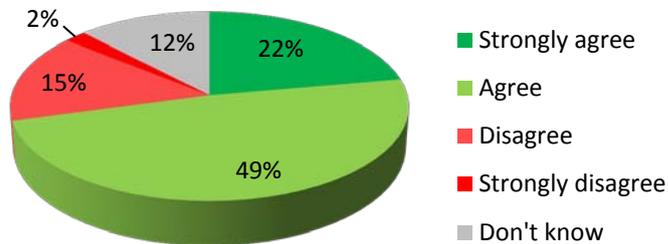
Given the significant changes, and the questions that remain about the support that GP commissioners will need in commissioning cancer services, the CCG undertook a survey to discover what support GPs themselves thought they would need to commission these services, and at what level they thought they should be commissioned. This briefing sets out the findings of the survey, and the steps that the CCG believes are necessary to ensure that outcomes and experience for cancer patients continue to improve.

Ensuring effective commissioning of cancer services

1. Supporting commissioning of cancer services

The CCG is calling for the Government to ensure that the move to GP commissioning does not have a detrimental impact on quality of cancer care and services. The Government’s recently published *Improving Outcomes: A Strategy for Cancer*⁶, acknowledges that commissioning for cancer is particularly complex. It is therefore essential that appropriate support and expertise is available to whoever is responsible for commissioning cancer services to ensure patient outcomes and experience of care continue to improve.

Figure 1: I will require specialist cancer commissioning advice to effectively commission cancer services



As demonstrated in Figure 1, 71% of GPs responded to our survey saying that they strongly agree/agree that they will require specialist advice to effectively commission cancer services. This number was even higher (82%) when GPs were asked whether GPs in their area involved in commissioning would require specialist advice to effectively commission cancer services. Only one in five GPs felt that they would not need any specialist advice to effectively commission cancer services. The full results from the survey are available in Annex 2.

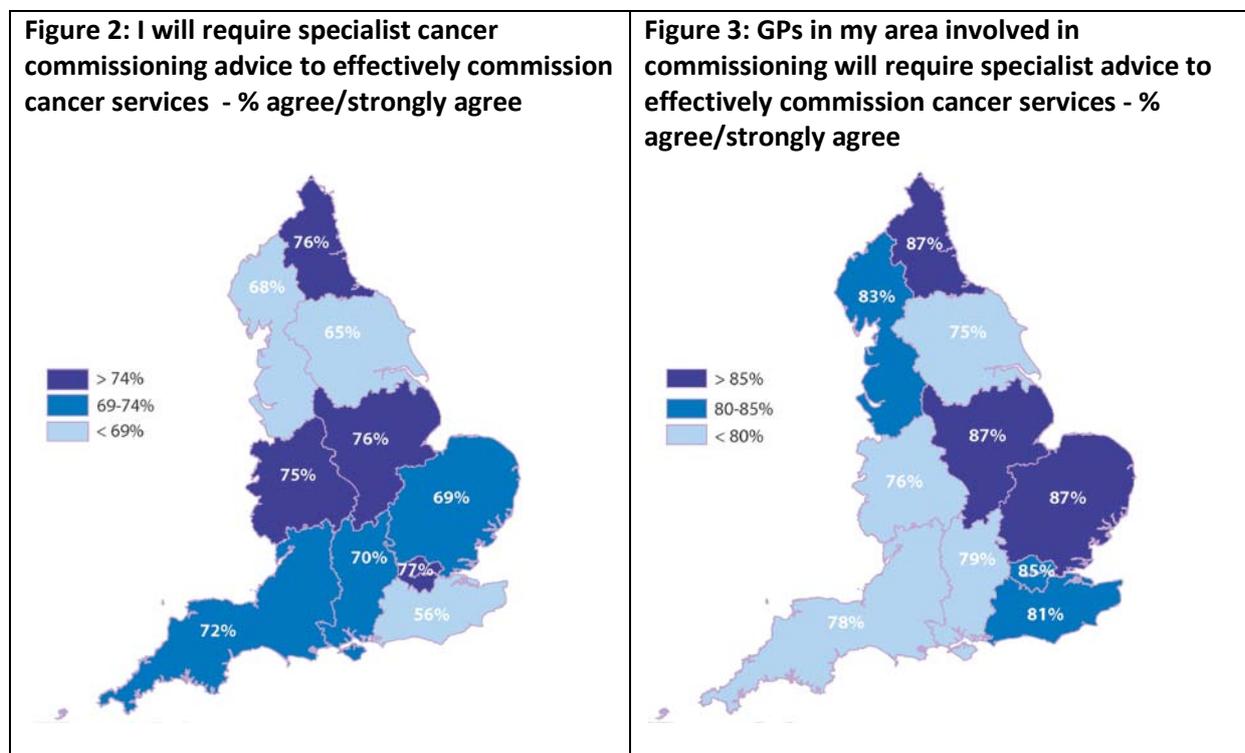
One of the key providers of cancer commissioning advice has traditionally been cancer networks. Cancer networks bring together service providers and commissioners to work collaboratively to plan and deliver high quality cancer services. Good cancer networks play a number of roles which the CCG believes must not be lost during the transition period to GP commissioning. These include:

- Provision of specialist commissioning expertise and advice on cancer services
- Leadership to ensure coordination of services across primary, secondary and tertiary care
- Guidance on how specialist cancer services should be commissioned and which bodies are most appropriate to commission them
- Support in developing cancer user involvement mechanisms
- Support in implementing the wider Department of Health Quality Innovation Productivity Prevention (QIPP) programmes
- Monitoring compliance with Improving Outcomes Guidance (and quality standards when these are rolled out)

A survey of primary care trusts (PCTs) carried out by the National Audit Office (NAO) in 2010 found that 99% of PCTs believe that they work well with their cancer network in the delivery of cancer services, with 88% using the advice of cancer networks on service improvement and design and 83% on planning and prioritisation⁷. The future of cancer networks under the NHS reforms is not yet clear. While a commitment has been made to fund cancer networks in 2011/12⁸, the CCG believes that this funding should be extended and made available until GP consortia are fully up and running to guarantee continuity of this important resource to commissioners.

In the longer term, the NHS Commissioning Board should commit to retaining the expertise of cancer networks. The CCG notes that Sir David Nicholson, Chair Elect of the NHS Commissioning Board, said in his letter to NHS Chief Executives dated 13 April that “there is a central role for (multi-professional clinical) networks in the new system as the place where clinicians from different sectors come together to improve the quality of care across integrated pathways”⁹.

There is notable regional variation in the level of support that GPs believe they will require to effectively commission cancer services. Only 56% of GPs in NHS South East believed that they would need support to commission cancer services, compared to 76% in NHS North East and NHS East Midlands and 77% in NHS London. Figures 2 and 3 demonstrate these variations further. These differences could be explained by a number of factors, including the level of awareness of commissioning services that GPs currently have, how involved their practice has previously been in practice-based commissioning, whether they have taken a special interest in cancer services and also the work and visibility of their cancer network locally.



The Department of Health and the NHS Commissioning Board should work with GPs throughout the transition to assess their need for specialist support. This should include early involvement with the Pathfinder Learning Network, the online hub that has been set up by the Department of Health to provide support, resources and information for GP pathfinder consortia. The Department of Health and NHS Commissioning Board should also consider the requirements that they place on the membership of consortia boards. The CCG believes that clinical representation on GP consortia boards could offer further support to the effective commissioning of cancer services.

Patient and public involvement is central to the effective commissioning of cancer services, and GP commissioners will need support to ensure that they are using effective methods to reach and engage with all patients and their families. Many of the current cancer networks have well developed models for involving people affected by cancer in reviewing and designing services. These models should be considered by GP commissioners as they develop their commissioning plans.

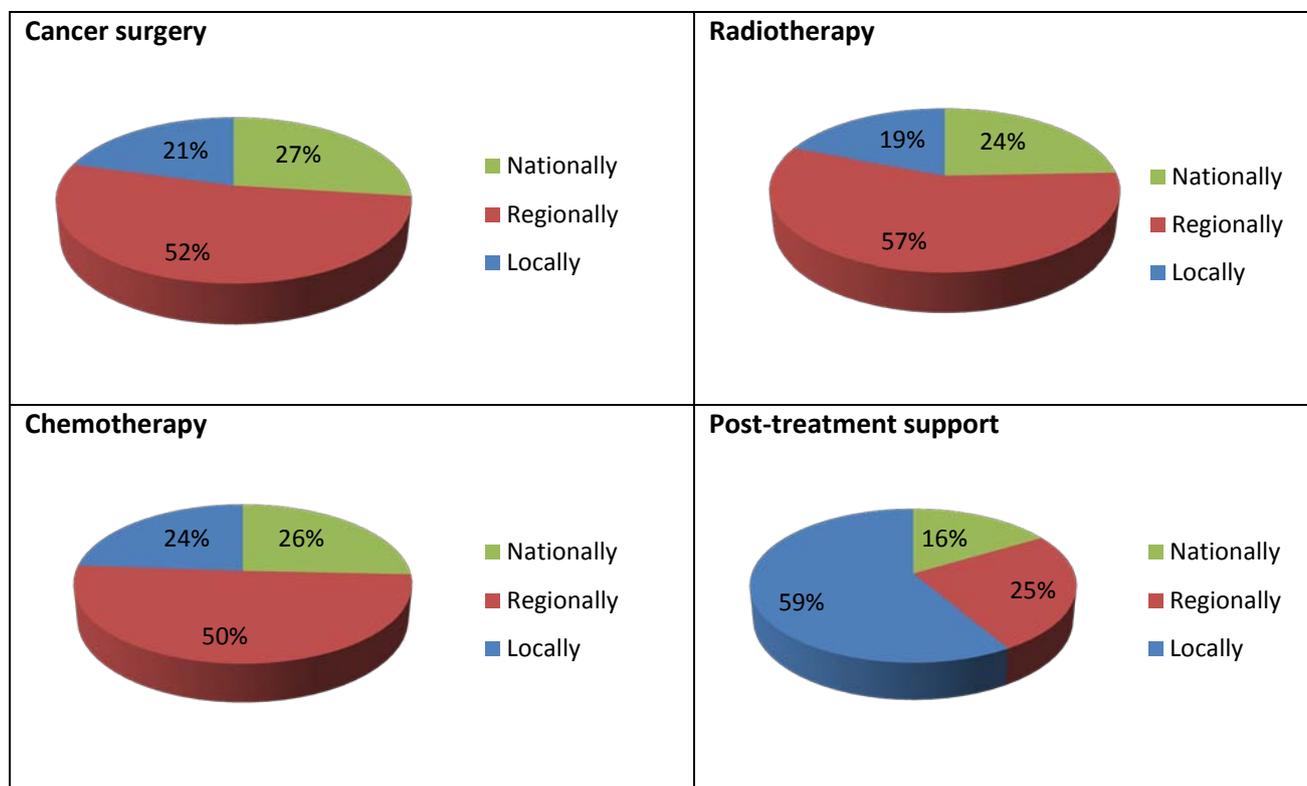
Recommendation 1: The Department of Health to ensure that cancer networks are properly funded until at least 2014 when GP commissioning consortia are fully bedded-in. We also look to the NHS Commissioning Board to ensure that the expertise currently held in cancer networks is retained for the longer term

2. Coordinated and integrated commissioning for cancer services

In order to be effective, the NHS Commissioning Board, cancer networks, GP consortia and local authorities will need to work together to commission appropriate, integrated cancer services that are tailored to local needs. *Improving Outcomes: A Strategy for Cancer* points out that “a significant amount of cancer care is best commissioned for populations covering 1.5 to 2 million. This includes chemotherapy and radiotherapy services¹⁰.” This population size is significantly higher than the population size of individual pathfinder GP consortia – the average population covered by a pathfinder consortium is currently just over 202,000¹¹. It will therefore be important that there is coordination of cancer commissioning at a regional and national level.

This regional focus is supported by the CCG survey of GPs. As Figure 4 demonstrates, when asked at what level surgery, radiotherapy and chemotherapy should be commissioned, few GPs thought that this should be at a local level. The majority thought that these services should be commissioned at a regional level, which could involve GP consortia working together to design services for a larger population, or working with a local cancer network to design the services.

Figure 4: At what level should each of the following cancer services be commissioned?



While most GPs believed that cancer surgery, chemotherapy and radiotherapy should all be commissioned at a regional or national level, a majority felt that post-treatment support should be

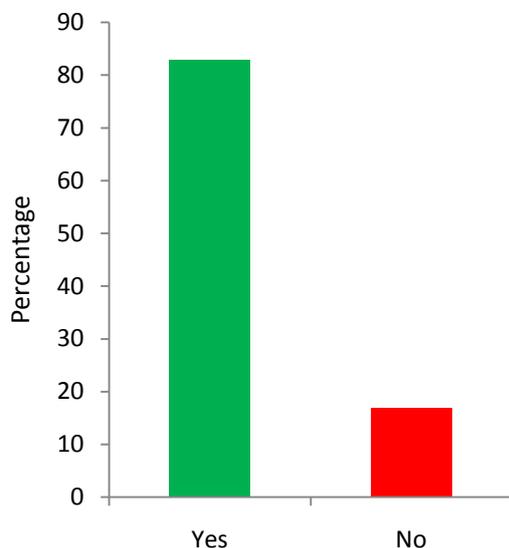
commissioned more locally. It is therefore likely that a number of different bodies will have responsibility for commissioning improved outcomes for cancer, including the NHS Commissioning Board, GP consortia and health and wellbeing boards. It will be essential that these bodies work together to ensure that there is a whole pathway view of cancer services.

Recommendation 2: The NHS Commissioning Board should commit to engaging in a robust consultation with the cancer community when developing the details of how effective cancer commissioning will be achieved. For some care it is appropriate that this should be commissioned at a regional or national level and GP consortia should be supported to commission collaboratively when appropriate. In order to commission high quality patient care, it is essential that there is integration and communication across the whole care pathway, including primary, secondary and tertiary care

3. Information for cancer commissioning

A key factor in supporting the commissioning of cancer services is timely and accurate data. In its report on progress made since the publication of the Cancer Reform Strategy (CRS)¹² in 2007, the NAO concluded that *“high quality information provides a basis for better decision-making and more effective assessment of performance. Aspects of cancer information have improved substantially since publication of the Strategy, but key gaps and limitations remain.”*

Figure 5: Are there any gaps or limitations in the information currently available to you to support the planning of cancer services in your PCT



As the new reforms are implemented, it will be essential to set out at an early stage how progress against outcomes, delivering greater choice, increasing patient and public involvement and tackling inequalities will be measured and meaningfully reported. A survey of PCTs¹³ and cancer networks¹⁴ carried out by the NAO highlighted limitations in the information currently available to support the planning of cancer services. Around 83% of PCTs and 89% of cancer networks responded that there are gaps in the information currently available to them. Among the gaps in data highlighted were demographic information, staging data including collection of data for metastatic disease, outcomes and financial information. Both PCTs and cancer networks also pointed to problems with the timeliness in the availability of information on cancer incidence, survival and mortality, as well as difficulty in accessing some data sources.

The CCG supports the Government’s plans to increase the quality and volume of information available in the NHS, as well as information to help patients make meaningful choices about their care. The National Cancer Intelligence Network (NCIN) has made an important contribution so far to improving data collection and analysis but more needs to be done on this. Systems should be streamlined between cancer registries and the national cancer data repository to ensure that data is made available in a more consistent and timely way. This will be critical to ensuring that

improvements in the commissioning of cancer services can be made and measured. Existing tools such as the Cancer Commissioning Toolkit should be developed to ensure ease of access to timely and accurate data for commissioners of cancer services.

Recommendation 3: GP consortia should be supported in the commissioning of cancer services by increased routine collection and timely publication of data from the national cancer data repository by 2013, particularly on cancer staging (including for advanced cancers), and more swift publication of data on cancer incidence, survival and mortality. This will help improve the planning and development of cancer services

4. Incentivising commissioning of cancer services

As well as being provided with expert support and information, the CCG believes that commissioners should be clearly incentivised to ensure high quality cancer services and patient experience in their local health economy. This is particularly important given historical variations in the quality of commissioning for cancer services.

The Health and Social Care Bill will place all NHS commissioners under a duty to improve quality in the NHS¹⁵. In order to support this, the NHS Commissioning Board will be developing a Commissioning Outcomes Framework (COF) to hold GP consortia to account on their success in improving outcomes for patients. The COF should be used to hold GP consortia to account on the cancer outcomes that they achieve, and indicators should incorporate rarer as well as more common cancers, paediatric/teenage and young adult cancers as a key sub-set of all patients, and measures of patient experience.

The use of NICE quality standards¹⁶ will be an important tool in defining high quality services in the NHS, public health and social care service, and the CCG believes that their development should be initiated as rapidly as possible, allowing for full consultation with the cancer community. The selection of topics to be developed should be based on clinical need as well as the current existence of guidance. When developed, quality standards should be used to set out the minimum in quality care that should be achieved, and should be included in commissioning guidance.

Recommendation 4: Commissioners to be incentivised to ensure high quality cancer services, with indicators in the Commissioning Outcomes Framework incorporating rarer as well as more common cancers and measures of patient experience

Recommendation 5: GP commissioners to be encouraged to consider how they can effectively involve people affected by cancer in reviewing and designing services

Conclusion

The commissioning of services in the NHS is undergoing significant change. This poses both opportunities and challenges to cancer services, and it is vital that the implications are fully understood and any risks to the quality of cancer services mitigated as the transition period progresses.

It is clear that commissioners will need expert support to commission cancer services. 82% of GPs believe that GPs in their area with responsibility for commissioning will need specialist advice to commission cancer services. In the short term this support may come from cancer networks, but their longer term future is unclear. The CCG believes that cancer networks should be properly funded until GP commissioning is fully established in 2014, and the NHS Commissioning Board should work with cancer networks to consider how their expertise can be maintained and made available to commissioners in the longer term.

A significant amount of cancer care is best commissioned for populations covering 1.5 to 2 million due to low patient throughput or capital costs of machinery. Given that the average GP consortium currently covers a population of 202,000, it is clear that (above and beyond specialised commissioning which will be undertaken by the NHS Commissioning Board) for some care it is appropriate that this should be commissioned at a regional or national level and GP consortia should be supported to commission collaboratively when appropriate. In order to deliver high quality patient care, it is essential that there is integration and communication across the whole care pathway, including primary, secondary and tertiary care. This was reflected in the views of GPs, the majority of who thought that cancer surgery (52%), radiotherapy (57%) and chemotherapy (50%) should be commissioned regionally. These views should be taken into account as the NHS Commissioning Board makes decisions about the level of commissioning for different services and draw on existing guidance. We believe that the cancer community should be consulted as these issues are considered.

As well as expert support, the CCG believes that commissioners of cancer services will need accurate and timely information about the needs of their local population and the quality of services in their area. This will include data on the stage of diagnosis, better information on the costs of cancer services and more timely information on cancer prevalence, incidence and mortality.

The CCG believes that these factors are critical to ensuring high quality commissioning of cancer services. Our members hope to work closely with the Department of Health and the NHS Commissioning Board as the plans for cancer commissioning are progressed and developed.

Acknowledgements and further information

The Cancer Campaigning Group

The Cancer Campaigning Group (CCG) is a coalition of 48 national cancer-related charities representing service providers, research, advocacy and campaigning groups for cancer patients and their families. Founded in 2002, the CCG is campaigning for world class prevention, treatment, support and care for every cancer patient in England bringing all services up to the standards of the best in Europe.

At this crucial time in the development of health and cancer services, the CCG enables cancer charities to speak and campaign with a single unified voice – pooling expertise, amplifying the impact of individual organisations, and ensuring that our messages are heard and acted upon by the Government and the NHS.

Please see our website at: www.cancercampaigninggroup.org.uk

The Cancer Campaigning Group Steering Group and Secretariat

The CCG's campaigning strategy and activities are developed by a steering group of representatives from six member charities – Breast Cancer Campaign, Cancer Research UK, Macmillan Cancer Support, The Prostate Cancer Charity, The Rarer Cancers Foundation and The Roy Castle Lung Cancer Foundation. MHP Health Mandate provides the Secretariat to the Group, including communications advice, support and implementation.

Supporters of the CCG

The CCG's work is supported by eleven pharmaceutical companies – AstraZeneca, Boehringer-Ingelheim, Bristol-Myers Squibb, Celgene, GlaxoSmithKline, Lilly, Novartis, Pfizer, PharmaMar, Roche and sanofi - and one medical technology company, GE Healthcare. Supporting organisations do not direct or control CCG strategy, activities or literature in any way. The CCG ensures that all its relationships with supporter organisations comply with the Association of the British Pharmaceutical Industry (ABPI) code of conduct governing the relationship between patient groups and pharmaceutical companies.

Contact details

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Annex 1 - About the survey

The CCG commissioned ComRes to carry out a survey in to GP attitudes to the commissioning of cancer services in February 2011. 817 GPs in England provided responses to the following questions:

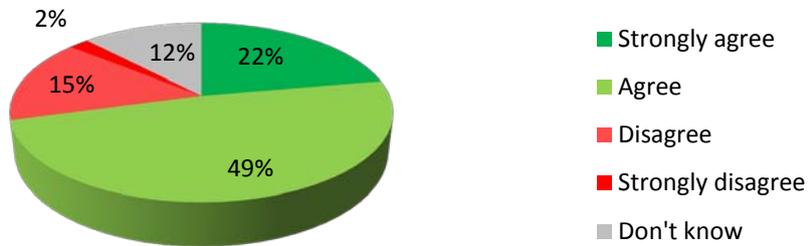
- 1) Do you agree or disagree with these statements? (strongly agree, agree, disagree, strongly disagree, don't know):
 - a) I will require specialist cancer commissioning advice to effectively commission cancer services
 - b) GPs in my area involved in commissioning will require specialist advice to effectively commission cancer services

- 2) At what level should each of the following cancer services be commissioned? (nationally, regionally, locally)
 - a) cancer surgery
 - b) radiotherapy
 - c) chemotherapy
 - d) post-treatment support for cancer patients

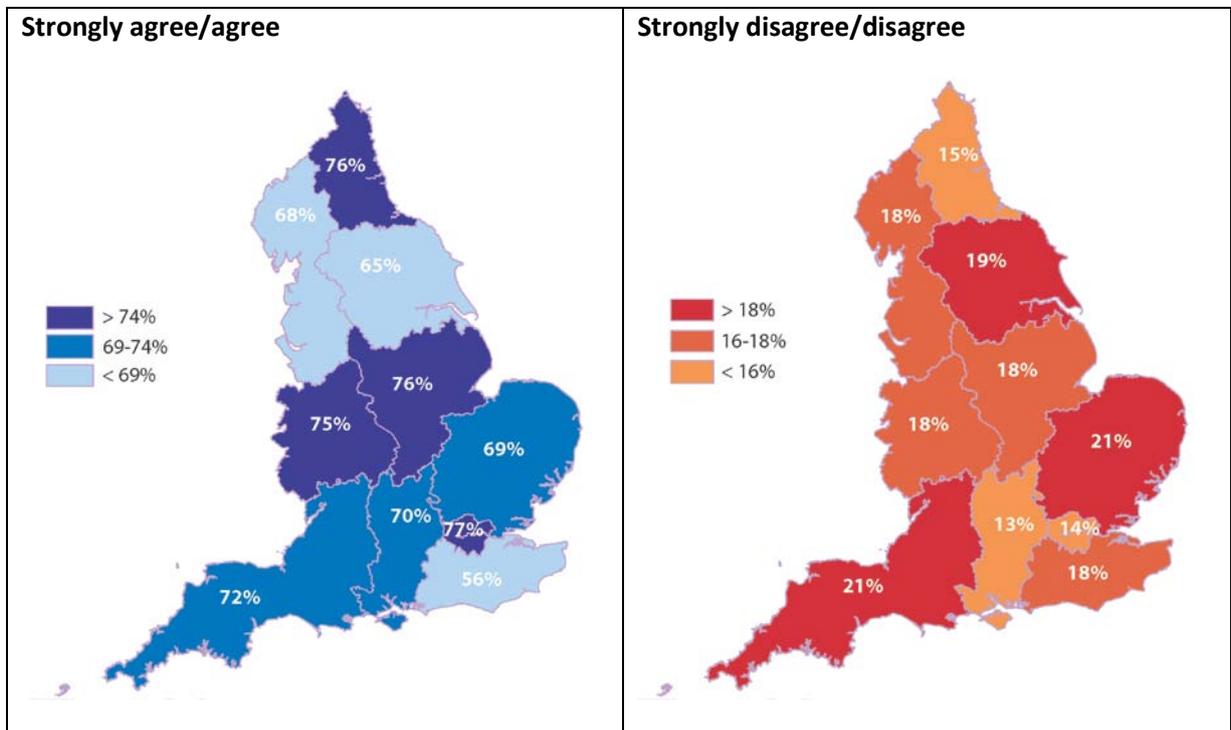
Annex 2 - Breakdown of GP survey results

1a) I will require specialist cancer commissioning advice to effectively commission cancer services

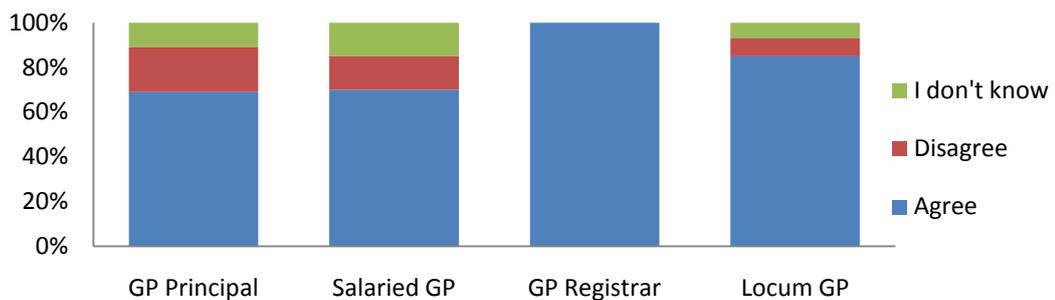
Overall



Regional

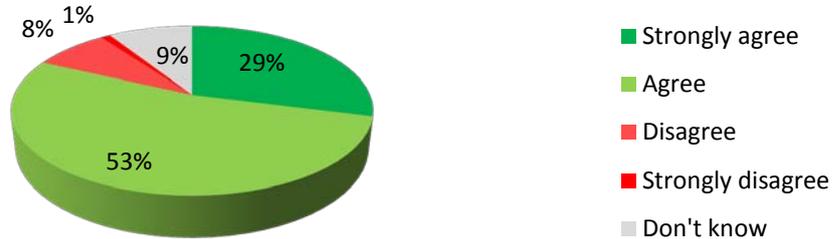


Type of GP

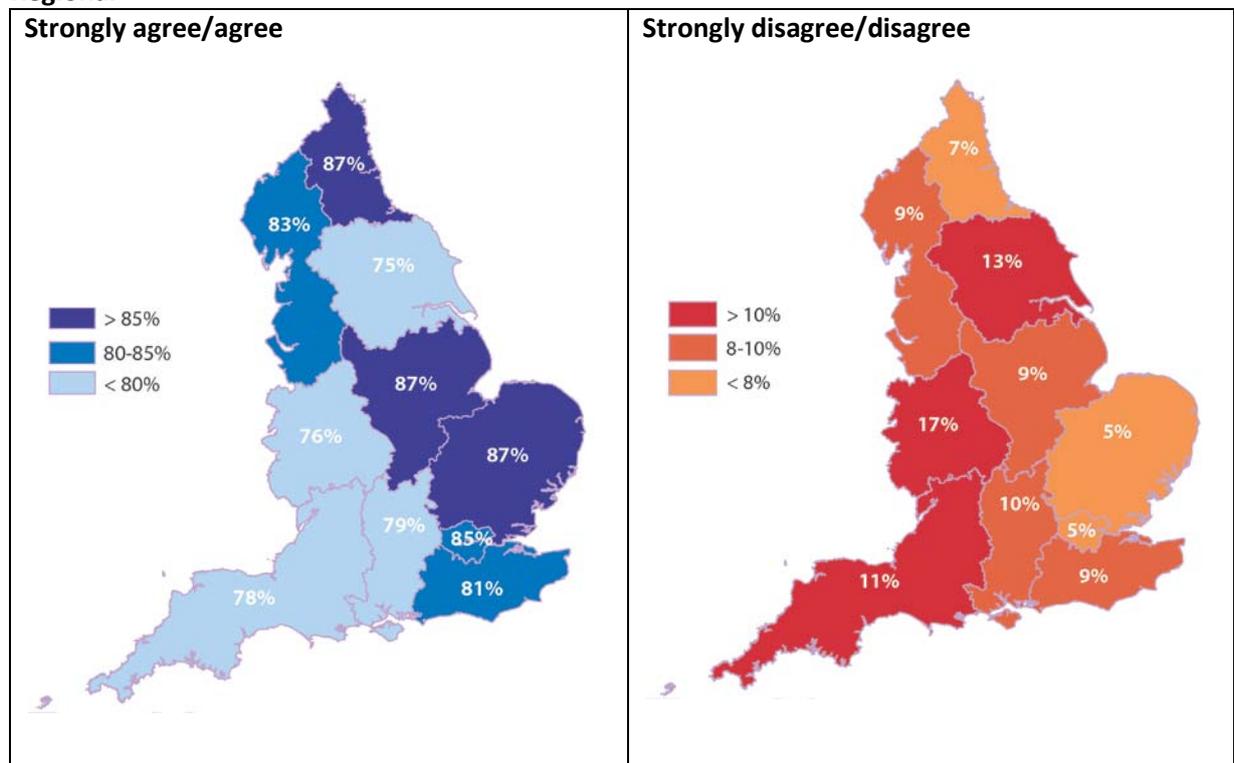


1b) GPs in my area involved in commissioning will require specialist advice to effectively commission cancer services

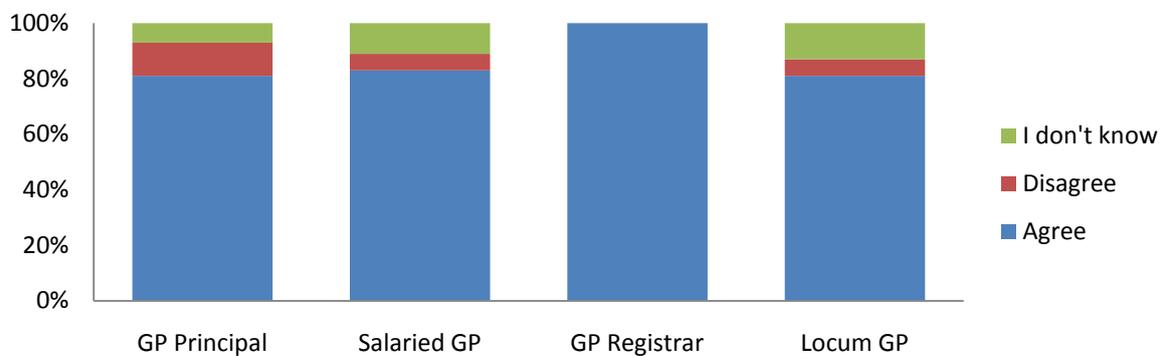
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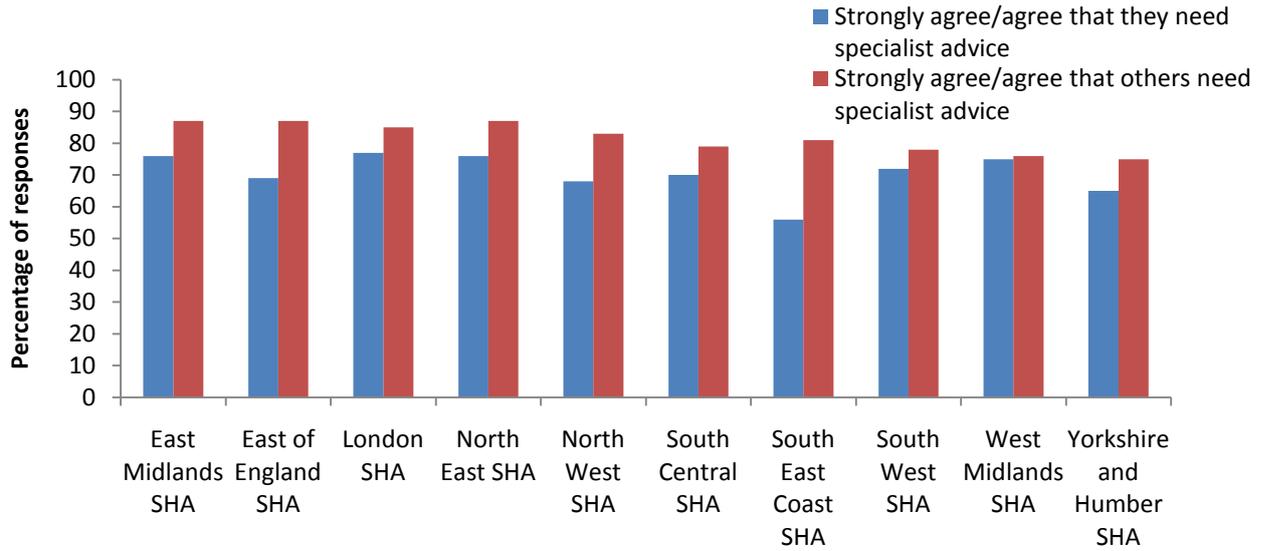
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Type of GP

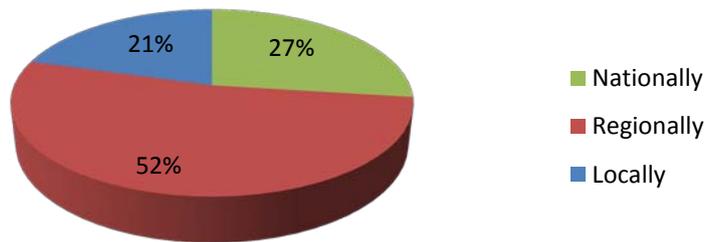


1a v 1b: Percentage of GPs who agreed to both statements

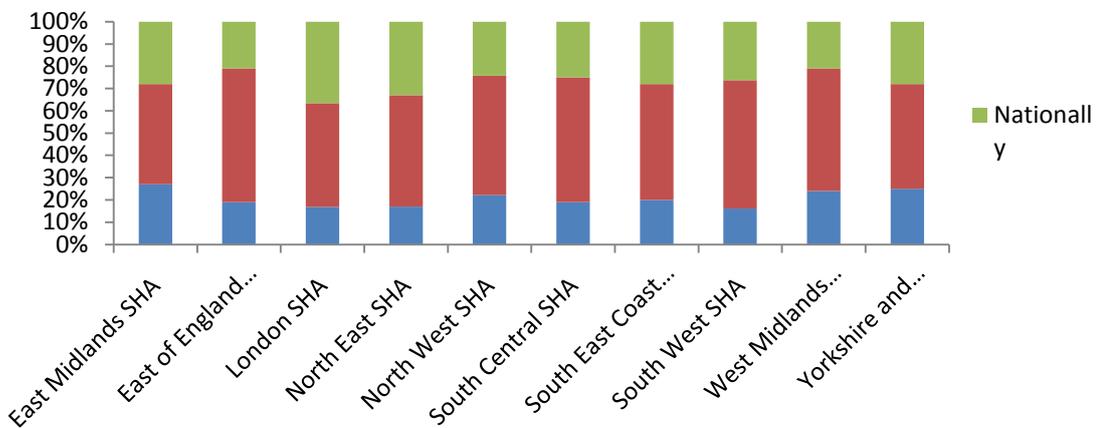


2: At what level should each of the following cancer services be commissioned?

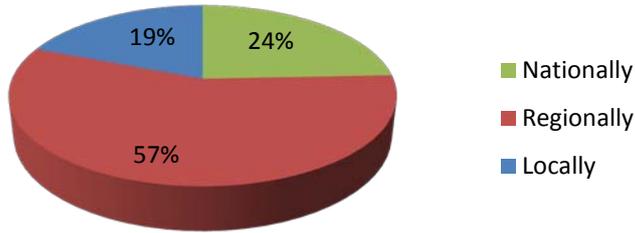
a) Cancer surgery



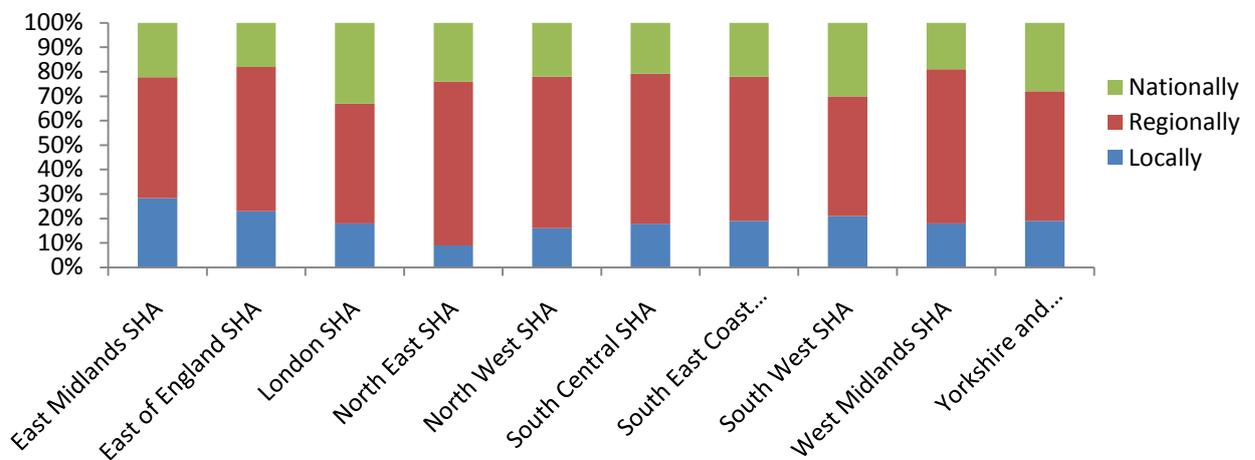
Regional breakdown



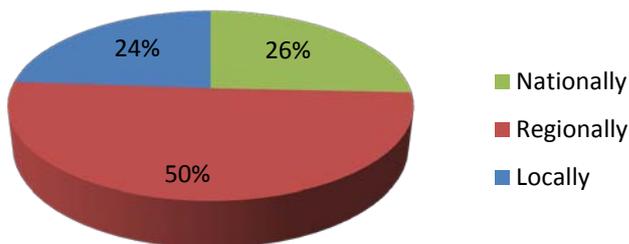
b) Radiotherapy



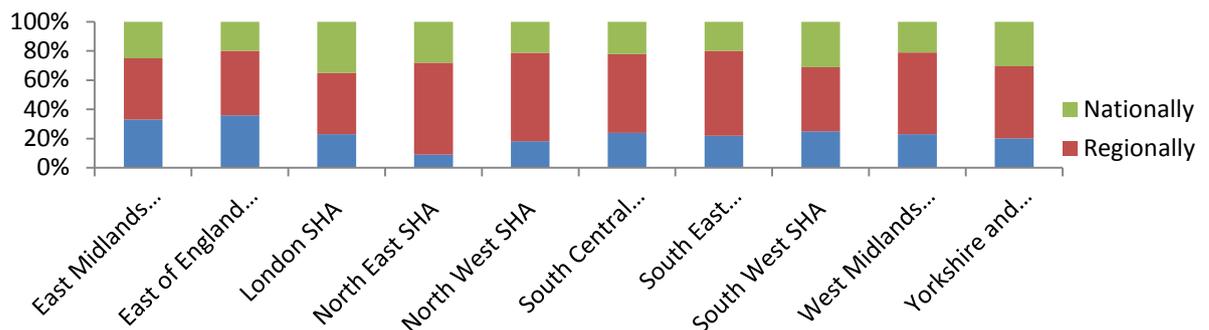
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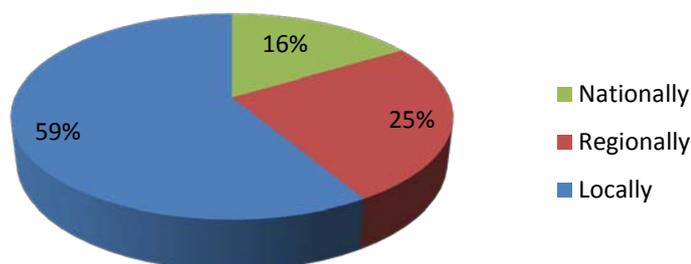
c) Chemotherapy



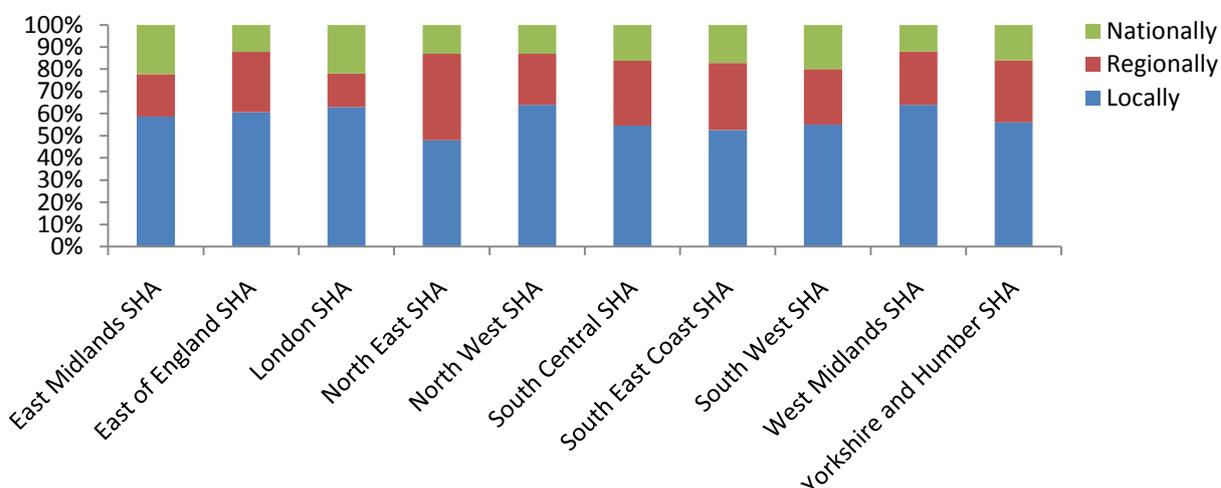
Regional breakdown



d) Post-treatment support for cancer patients



Regional breakdown



¹ Department of Health, *Improving Outcomes: A Strategy for Cancer*, January 2011

² NHS Specialised Services, available at: <http://www.specialisedservices.nhs.uk/>

NHS Specialised Services is the national organisation responsible for the commissioning of specialised services that help improve the lives of children and adults who have very rare conditions. In England, there are 10 Specialised Commissioning Groups (SCGs) that commission specialised services for their regional populations, which range in size from 2.8 million people to 7.5 million people.

³ Department of Health, *Improving Outcomes: A Strategy for Cancer*, January 2011

⁴ Total Politics, *Lansley's impossible task*, December 2010, available at:

http://i.comresupdates.eu.com/CmpDoc/2010/17299/30536_hawkins_tpdec10.pdf?dm_i=DCJ,BTPV,399D81,X,FYN,1

⁵ nfpSynergy, Primary Healthcare Professionals Monitor, September 2010. The 8% figure includes GPs who indicated any of the following interests: Bowel cancer, Breast cancer, Lung cancer, Other specific types of cancer (not bowel, breast or lung), All types of cancer, and Cancer – survivorship

⁶ Department of Health, *Improving Outcomes: A Strategy for Cancer*, January 2011

⁷ National Audit Office, *Delivering the Cancer Reform Strategy, A census of primary care trusts*, November 2010

⁸ Department of Health, *Improving Outcomes: A Strategy for Cancer*, January 2011

⁹ Department of Health, *Sir David Nicholson: Dear Colleague Letter*, 13 April 2011

¹⁰ Department of Health, *Improving Outcomes: A Strategy for Cancer*, January 2011

¹¹ Department of Health, *GP Pathfinder Consortia*, 2011, accessed on 20 April 2011

¹² Department of Health, *Cancer Reform Strategy*, December 2007

¹³ National Audit Office, *Delivering the Cancer Reform Strategy, A census of primary care trusts*, November 2010

¹⁴ National Audit Office, *Delivering the Cancer Reform Strategy, A census of cancer networks*, November 2010

¹⁵ Department of Health, *Health and Social Care Bill 2011*

¹⁶ NICE, *Quality standards*, March 2011, available at:

<http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp>