Cancer Commissioning Strategy for Northamptonshire

2015-2017

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<tr>
<th>Date</th>
<th>30 April 2015</th>
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<tbody>
<tr>
<td>Version</td>
<td>v1.1</td>
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### Version Control

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<th>Version</th>
<th>Author</th>
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<tr>
<td>0.1</td>
<td>Lola Banjoko</td>
<td>27/10/2014</td>
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<td>0.2</td>
<td>Lola Banjoko/ Linda Dunkley</td>
<td>10/12/2014</td>
<td>Extensive stakeholder review (Appendix 1)</td>
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<td>1.0 Final*</td>
<td>Lola Banjoko/ Linda Dunkley</td>
<td>30/03/2015</td>
<td>Feedback from Dr Matthew Davies, Clinical Executive Director for Strategy, Nene CCG Dr Joanne Watt, Clinical Cancer Lead Nene &amp; Corby CCGs Dr Naomi Caldwell, Macmillan GP Nene &amp; Corby CCGs Dr Joanne Warcaba, Macmillan GP Nene &amp; Corby CCGs</td>
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<td>1.1</td>
<td>Linda Dunkley</td>
<td>30/04/2015</td>
<td>Feedback from Northampton General Hospital (NGH)</td>
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- Northampton General Hospital
- Dr Michael Ogunlokun - Service Manager Commissioning and Policy, Public Health and Well Being Directorate, Northampton County Council

**Presentations to the following groups:**

<table>
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<tr>
<th>Medical Directorate Advisory Group</th>
<th>26 March 2015</th>
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<tbody>
<tr>
<td>Nene CCG &amp; Corby CCG Joint Executive Commissioning Board Approval</td>
<td>Approved 8 April 2015</td>
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1. Executive Summary

Significant improvements have been made in treatment and survival in cancer, but there now needs a step-change in the way cancer service provision is delivered for people living with the disease and the role the patient plays within that.

Changes in the commissioning and provider landscape requires coordination and integration between key organisations, particularly Public Health England, i.e. Local Authority, Clinical Commissioning Groups (CCGs), and NHS England to ensure the entire patient pathway from prevention to end of life is seamless.

NHS England, Public Health England, and NHS Right Care commissioning for value pack issued October 2014 identified cancer as one of the priority areas which will offer Northamptonshire the best opportunities to improve healthcare for populations and ensure value for money for the local health system.

To respond to the local challenges, Nene CCG and Corby CCG have highlighted cancer as one of the priority areas for action, as outlined in the 2015/16 Commissioning Intentions.

Areas of focus for 15/16 will include the Oncology alliance with University Hospitals Leicester (UHL), Northampton General Hospital (NGH), and Kettering General Hospital (KGH) to improve the pathway for patients and make best use of resources as well as addressing recommendations in the 2013 Cancer Peer review.

The commissioning strategy aims to address the various challenge points in the pathway provided by different organisations as follows:

- **Prevention** by addressing risk factors and improving the screening uptake

- **Early diagnosis** by shifting from detection due to symptoms, to detection as a result of screening using tools such as practice profiles, cancer decision toolkit, improve the appropriate use of 2-week wait and direct access; communication and engagement of the public by leveraging on health checks, annual flu clinic appointments, and community outlets such as pharmacies

- **Prompt high quality treatment** by addressing patient and system initiated delays. Delivering integrated end to end seamless 62-day pathways; improved patient outcomes and experience using a very efficient model of care. To do this the CCG will need to work closely with NHS England on the commissioning of the various elements of the 62 days referral to treatment pathway.

- **Survivorship and crisis management** - with improvements in early detection and rapid advances in treatment, we should expect even larger numbers of people living with and beyond cancer, and greater numbers of people acting as carers for people with cancer. This requires a shift away from the medical model of care to one that
sees the patient and the public being empowered to take up ownership of their care. To enable this cancer pathways should be linked to the National Cancer Survivorship Initiative (NCSI) and aligned to the CCGs’ Care Closer to Home strategy.

Enablers such as robust governance and leadership at all levels across the county working with key stakeholders such as the public, patients and the third sector will be required to drive through delivery in primary, community and secondary care. Additionally, the Quality and Innovation (CQUIN) framework for 2015/16 will be utilised to support improvements in the quality of services and the creation of new, improved patterns of care in secondary care.

It is worth noting that the CCGs have already developed a strong working relationship with Macmillan Cancer Support in the area. Macmillan have invested and continue to invest significant funding to aid service improvements across the county and support Macmillan professionals in post, and are seen as a key enabler in helping the CCGs in meeting the outcomes of this strategy.

It takes various organisations to treat and control cancer including public health professionals, GPs, consultants, oncologists, nurses, pharmacists, therapists, psychologists and community volunteers. As cancer patients go along the patient pathway, they also require different diagnostic, treatment and support services, often at different facilities.
2. Overview

Cancer is still the biggest cause of premature death (under 75 years) in the United Kingdom\(^1\),\(^2\),\(^3\). The number of people living with and beyond cancer is set to rise to 4 million (35,700 in Northamptonshire)\(^4\) by 2030. Significant improvements have been made in treatment and survival in cancer, but it now needs a step-change in the way cancer service provision is delivered for people living with the disease and the role the patient plays within that. The patient pathway for cancer stretches from prevention; raising awareness of symptoms; early presentation to primary care; improved appropriate referral; timely treatment and specialist care; care close to home where appropriate; good survivorship and palliative care.

April 2013, brought changes to the NHS with new commissioning arrangements covering the various parts of the cancer pathway as follows:

- **Public Health** teams within Local Authorities take on responsibility for prevention and population awareness of cancer signs and symptoms
- **Clinical Commissioning Groups** (CCGs) have responsibility for the commissioning of common cancer services as well as early diagnosis, services for patients living with and after cancer as well as end of life care
- **NHS England** has responsibility for the direct commissioning of specialist services including chemotherapy and radiotherapy and primary care
- **Public Health England** has responsibility for population screening

<table>
<thead>
<tr>
<th>What</th>
<th>Population awareness</th>
<th>Screening</th>
<th>Early diagnosis and treatment</th>
<th>Specialist services</th>
<th>Living with and beyond cancer (survivorship) &amp; end of life care</th>
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<td>Local authority</td>
<td>Public Health</td>
<td>CCGs</td>
<td>NHS England</td>
<td>CCGs</td>
<td>Patients, Public and Third sector</td>
</tr>
</tbody>
</table>

\(^1\) Office for National Statistics. Mortality Statistics: Deaths registered in England and Wales (Series DR).  
\(^2\) General Register Office for Scotland. Vital Events Reference Tables.  
\(^3\) Northern Ireland Statistics and Research Agency. Registrar General Annual Reports.  
\(^4\) National Cancer Intelligence Network – Cancer Commissioning Toolkit
Headlines for Nene CCG and Corby CCG

The following headlines for Nene CCG and Corby CCG have been taken from Local Cancer Intelligence which is a collaboration between Macmillan Cancer Support and Public Health England’s National Cancer Intelligence Network (NCIN), combining the best data and insights from NCIN, Macmillan and other sources to help understand the local burden of cancer.

<table>
<thead>
<tr>
<th>Headlines for NHS Nene CCG</th>
<th>Headlines for NHS Corby CCG</th>
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<tr>
<td><strong>Prevalence</strong></td>
<td><strong>Prevalence</strong></td>
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<tr>
<td>As of the end of 2010, around 17,500 people in the CCG were living with and beyond cancer up to 20 years after diagnosis. This could rise to an estimated 34,000 by 2030.</td>
<td>As of the end of 2010, around 1,700 people in the CCG were living with and beyond cancer up to 20 years after diagnosis. This could rise to an estimated 3,300 by 2030.</td>
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<td><strong>Incidence</strong></td>
<td><strong>Incidence</strong></td>
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<tr>
<td>There are 591 new cancer diagnoses per 100,000 people each year. This is similar to the England average.</td>
<td>There are 610 new cancer diagnoses per 100,000 people each year. This is similar to the England average.</td>
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<tr>
<td><strong>Mortality</strong></td>
<td><strong>Mortality</strong></td>
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<tr>
<td>There are 299 cancer deaths per 100,000 people each year. This is similar to the England average.</td>
<td>There are 371 cancer deaths per 100,000 people each year. This is higher than the England average.</td>
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<td><strong>One Year Survival</strong></td>
<td><strong>One Year Survival</strong></td>
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<td>One-year cancer survival is 67%. This is poorer than the England average of 68%.</td>
<td>One-year cancer survival is 68%. This is similar to the England average of 68%.</td>
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<tr>
<td><strong>Five Year Survival</strong></td>
<td><strong>Five Year Survival</strong></td>
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<tr>
<td>Five-year cancer survival is 47% in your Area Team. The England average is 48%.</td>
<td>Five-year cancer survival is 47% in your Area Team. The England average is 48%.</td>
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<td><strong>Patient Experience</strong></td>
<td><strong>Patient Experience</strong></td>
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<td>87% of people rate their overall care as excellent or very good. The England average is 88%. People rate each aspect of their care differently: e.g. 61% reported that hospital and community staff always worked well together (compared with the England</td>
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Cancer a clinical priority

Northamptonshire Local Authority 2013 Joint Strategic Needs Assessment highlighted lung cancer as the second highest cause of death for men in Northamptonshire, accounting for 7% of deaths.

Deaths from cancer in five Nene CCG district boroughs are statistically significantly lower than the England rates. However, Northampton and Kettering district councils have statistically significantly higher deaths in comparison to deaths in England. Men in Northampton and Kettering have statistically significantly higher deaths from cancer in comparison to deaths from cancer for other men in England. Death rates from breast, lung and colorectal cancer are statistically significantly higher when compared with that of other cluster CCGs5, and therefore will be priority areas for improvement6.

Deaths from cancer in Corby are significantly higher in comparison to deaths in England. Death rates from breast cancer in Corby are statistically significantly lower when compared with that of other cluster CCGs. Death rates from lung and colon cancer in Corby are statistically significantly higher when compared with that of other cluster CCGs and therefore will be priority areas for improvement7.

There is no current information about death from prostate cancer in Nene or Corby CCGs. This lack of prostate cancer information is the subject of further investigation8.

NHS England, Public Health England and NHS Right Care commissioning for value pack issued October 2014 identified cancer as one of the priority areas which will offer the best

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5 NHS South Derbyshire CCG, NHS East and North Hertfordshire CCG, NHS Bedfordshire CCG, NHS Herts Valley CCG, NHS Gloucestershire CCG, NHS Cambridgeshire and Peterborough CCG, NHS Oxfordshire CCG, NHS Somerset CCG, NHS Wiltshire CCG and NHS Mid Essex CCG

6 Public Health Cancer Briefing for Nene CCG Feb 2015

7 Public Health Cancer Briefing for Corby CCG Feb 2015

8 Public Health Cancer Briefings for Nene CCG & Corby CCG Feb 2015
opportunities to improve healthcare for populations and improve the value that populations receive from investment in their local health system as shown in the two diagrams below:

Nene CCG Health Economy Headlines 2014


Corby CCG Health Economy Headlines 2014

Nene CCG and Corby CCG have identified the following priority areas for action, as outlined in the 2015/16 Commissioning Intentions.

- Preventing people dying prematurely by improving early identification of suspicious symptoms in primary care
- Enhancing quality of life for people by improving outcomes and delivery of the national cancer survivorship programme
- To ensure treatment is commenced without delay by delivering the 62day referral to treatment national target

Nene CCG and Corby CCG will ensure that there is equitable access for services across the county with particular focus on vulnerable groups. The CCGs will work closely with the East Midlands Strategic Clinical Network (EMSCN) to ensure best practice is implemented wherever possible. The EMSCN are currently producing timed best-practice pathways for lung, breast and colorectal.

3. Local Challenges

Northampton General Hospital (NGH) is the cancer regional hub serving Northamptonshire. Up until early 2013 it also served North Bucks (Milton Keynes Hospital), but with this arrangement reducing it has resulted in a reduction in clinical activity. NGH needs to maintain the levels of clinical activity and is therefore exploring an Oncology alliance with University Hospital Leicester (UHL) and Kettering General Hospital (KGH) to improve the pathway for patients and make best use of resources.

The 2013 Cancer Peer review recommended that both KGH and NGH have Acute Oncology teams in place. There have been recruitment issues and posts are currently being appointed to. The review also recommended that NGH have a fully functioning flagging system which alerts clinical staff at the point of presentation that the patient has cancer and is having active treatment – testing around this system is underway. At the time of writing this document, KGH has not met the 62 day cancer waiting time standard overall for seven out of the past ten months, and NGH has not met the standard overall for the past ten months.

As previously mentioned, NGH is holding executive level Oncology alliance meetings with UHL and KGH, with involvement from the Cancer Services Network. The purpose of the proposed Oncology alliance is to secure a long-term, sustainable solution for Oncology across Leicestershire, Northamptonshire and Rutland (LNR). The Oncology alliance would seek to ensure the clinical and financial viability of all partners.

Challenges at various points of the pathway

NHS England, Public Health England and NHS Right Care commissioning for value October 2014 pack demonstrates challenges at various points in the pathway provided by different organisations.
In Nene CCG, under 75 mortality rates for breast, lung and colon cancer are significantly lower when compared with rates for other cluster CCGs\textsuperscript{11}. See appendices 2, 3 and 4.

In Corby CCG, under 75 mortality rates for breast cancer are significantly lower when compared with rates for other CCGs. Mortality rates for lung and lower gastrointestinal (GI) cancers are significantly higher for Corby CCG when compared with rates for other CCGs\textsuperscript{12}. See appendices 2, 3 and 4.

**Emergency services**

Part of our strategy is to engage with our member practices to identify and understand the reasons for variation between practices.

The diagram below\textsuperscript{13} shows the proportion of newly identified tumors first presenting as an emergency for both Nene CCG and Corby CCG. For the period Jan-Dec 2012 the percentage for Nene CCG was 18.65\%, and Corby 25.1\%.

\begin{figure}
\centering
\includegraphics[width=\textwidth]{emergency_services_graph.png}
\caption{Proxy measure for emergency presentations for cancer\textsuperscript{13}}
\end{figure}

\begin{itemize}
\item \textsuperscript{11} Public Health Cancer Briefing for Nene CCG Feb 2015
\item \textsuperscript{12} Public Health Cancer Briefing for Corby CCG Feb 2015
\item \textsuperscript{13} National Cancer Intelligence Network – Cancer Commissioning Toolkit
\end{itemize}
The number of emergency cancer admissions to KGH/NGH (Sept 2013 to Aug 2014) was 2,516 and cost circa £7.3M.

An audit undertaken by NGH suggests that a high number of admissions are due to palliative care needs and non-elective work. There is recognition that unplanned admissions could be avoided especially for those approaching end of life.

4. Addressing the Challenges

4.1 Commissioning for Prevention

NHS England 5 year Forward View (October 2014) highlights the need for **radical upgrade in prevention and public health** as one of the key elements required to ensure the sustainability of the NHS.

Preventing cancer is the responsibility of each local health economy by helping people through specific programmes and multi-agency partnerships on reducing tobacco use, maintaining a healthy weight, exercise, diet, alcohol harm reduction and especially smoking cessation, with particular focus on vulnerable groups.

There is evidence that there are a number of preventable or modifiable behaviours that may reduce an individual’s risk of getting cancer. It is estimated that approximately 40% of cancers are attributed to lifestyle and environmental factors\(^{14}\), meaning there is great potential to stop people in Northamptonshire from developing cancer in the first place, delivering better patient experience and savings from the NHS.

The CCGs will work with Public Health and our providers to address the risk factors.

**Recommendations**

- Commission well-evidenced primary prevention programmes focussed on the key risk factors linked to Northamptonshire’s biggest diseases (**NHS England, Local Authorities-Public Health and CCGs**)

- Ask Health and Wellbeing boards to influence local commissioning arrangements to ensure measures to prevent cancer and other diseases are embedded across all activities and support the reduction in health inequalities (**NHS England**)

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\(^{14}\) National Cancer Intelligence Network – Cancer Commissioning Toolkit
5. Screening

Population screening contributes to improving cancer mortality and morbidity. However, there is scope to improve the coverage and uptake as well as the equity of uptake of the national breast, bowel and cervical cancer screening programmes across Northamptonshire.

Cancer is associated with socioeconomic deprivation. Amongst communities where there is deprivation, and in ethnic minority groups, nationally take-up is low. Screening in areas of high socioeconomic deprivation and amongst people of ethnic minorities should be encouraged. This is important because those who miss screening are probably those most in need of it, and cases can be missed.

Corby has a high level of deprivation and shows high rates of incidence and mortality especially of lung cancer, prostate cancer and all cancers combined compared with Northamptonshire, East Midlands and England, and mortality from colorectal cancer in females compared with East Midlands and England. In Northamptonshire, prostate cancer is more common than in the East Midlands and England.\(^{15}\)

5.1 Breast screening\(^ {16}\)

Breast cancer screening coverage figures for all six Nene CCG districts (Daventry, East Northants, Kettering, Northampton, Wellingborough and South Northants) and Corby are significantly better than the England figure of 75.9%. This positive picture is seen across East Midlands and Northamptonshire. **Nene CCG had significantly higher coverage rates for breast cancer screening** when compared to other cluster CCGs.

5.2 Bowel screening\(^ {17}\)

Performance for bowel screening at 56.7% (Q1 2014/15) reaches the national standard of 52% uptake but does not reach the South Midlands and Hertfordshire Area Team aspirational target of 60%\(^ {18}\). **Coverage rates for colon cancer screening in Corby are significantly lower** when compared with coverage in other cluster CCGs. There has also been a national drop in uptake as the programme develops and recalls previous participants. **The average colon cancer coverage figures** of 60.7% for 2012/13, 56.1% for 2013/14 across Nene CCG would suggest that this falling trend is not just a national challenge.

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15 Northamptonshire Joint Strategic Needs Assessment
16 Public Health Nene CCG & Corby CCG Cancer Briefings Feb 2015
17 Public Health Nene CCG & Corby CCG Cancer Briefings Feb 2015
18 Hertfordshire & South Midlands Area Team - Screening Programmes Performance Report Q1 (2014/15)
Bowel Scope Screening (55yrs) commenced in March 2014 and is gradually being rolled-out. Kettering is receiving a number of visitors at present as other programmes prepare for implementation. Northampton is scheduled to start inviting in March 15 with subjects being screened from August 2015.

5.3 Cervical screening

In Nene, cervical screening coverage figures for all eligible women for all six districts shows that coverage figures in Daventry, East Northants and South Northants are significantly better than the England value of 74.2%. In the same vein, coverage figures for Kettering, Northampton and Wellingborough respectively are significantly lower than the England value.

In Corby, the cervical cancer screening coverage figure of 71.5% is significantly lower than the England average figure of 74.2%. The East Midlands and Northamptonshire respective figures are 76.6 % and 74%.

Greater integration is needed across the patient pathways between the screening providers (primary, community and secondary care), diagnostic services (pathology, imaging) and treatment services.

Recommendations

- Develop education programmes to reduce variation in screening and uptake rates (Public Health England, Local Authorities and CCG)
- Explore contractual levers with dentistry, pharmacy and ophthalmology that can be used to increase cancer awareness messaging and sign posting (NHS England)
- Improve integration between screening providers, diagnostic services and treatment services (NHS England, Local Authorities and CCG)

6. Early Diagnosis

Early presentation by patients and symptom recognition by GPs is very important. Local awareness and early diagnosis programmes have helped to stimulate this. A GP usually sees fewer than ten patients with cancer each year, so symptom recognition is not straightforward. Of the patients referred via the two-week wait route to a consultant, only 10% to 20% are found to have cancer in Northamptonshire. GPs have an option to request some tests directly for their patients - the aim is to work with primary and secondary care to improve direct access to enable early diagnosis. To ensure effective utilisation of 2 week wait...
referral and capacity in secondary care CCGs can provide reports on conversion rates to practices to be used as a feedback loop for improving referrals. The reports will highlight unwarranted variation, and are available on the National Cancer Intelligence Network’s Cancer Commissioning Toolkit (CCT) under practice profiles, freely available for CCGs to access and use.

Professor Sir Mike Richards CBE, National Cancer Director, has stated that:

“Efforts now need to be directed at promoting early diagnosis for the very large number (over 90%) of cancer patients who are diagnosed as a result of their symptoms, rather than by screening.”

Achieving earlier diagnosis has the greatest potential for improving outcomes and survival for cancer patients in Northamptonshire. The implications for increasing earlier detection include increasing the volumes of patients referred for diagnostics.

Across the East Midlands Strategic Clinical Network approximately 22% of cancer diagnoses will occur during an acute admission\(^\text{21}\) where the potential for a successful outcome is much lower. The types of cancer presenting are for different tumour sites and where patients have been on many journeys through primary care – we will be looking at these sites with our member practices. A percentage of these will enter Accident and Emergency (A&E) as a result of a direct referral from the GP to enable fastest access for the patient into secondary care. Acute Oncology services will enable both a better patient experience and outcomes for these patients. Reducing the number of people first diagnosed in A&E must be a priority in order to improve cancer outcomes in Northamptonshire.

The 13/14 Awareness Early Diagnosis audit of cancer diagnosis in primary care carried out by Public Health showed that a greater proportion of cancer patients who were housebound or who had communication difficulties first presented with their symptoms at A&E than patients who were neither housebound nor had any communication difficulties.

For early detection and awareness, the strategy seeks to tackle each element of the pathway that can lead to a delay in diagnosis as follows:

1. **Public delay** - Fear at what the doctor might find, worry about wasting the GPs time, lack of knowledge about specific cancer signs and symptoms and inability to make a GP appointment at a suitable time can all contribute to a public delay in getting medical help. A series of initiatives are proposed to tackle this include awareness campaigns of common signs and symptoms through further roll out and promotion of the national Be Clear on Cancer national campaigns; making every contact inside and outside the health care environment count e.g. Talk Cancer programme.

\(^{21}\) National Cancer Intelligence Network – Cancer Commissioning Toolkit
2. **GP delay** - Supporting GPs to be able to spot signs and symptoms of cancer and refer appropriately and in a timely manner is critical to reducing delays at the GP surgery.

3. There are a number of tools that can be used to support GPs to refer appropriately and promptly. Local GP leadership is vital to making sure these tools are received and become business as usual.

4. **System delay** - Insufficient and appropriate use of capacity in secondary care to meet rising referral demand can also play a role in delaying the time it takes to get a diagnosis. Delivering best practice and robust pathway management using tools such as access policies, milestones, timeframes and escalation trigger points are essential tools to enable providers to deliver the 62days national target e.g. improving direct access for GPs and consistency across the county.

5. **Targeted initiatives for high risk populations** across Northamptonshire, wide variations in cancer outcomes exist and inequalities persist in communities living side by side driven by factors including ethnicity, gender and socio-economic status. If Northamptonshire is to truly reduce variation and bring Northamptonshire’s outcomes up to match best in world, it is recommended that targeted interventions are commissioned to reach high risk populations. This will close the loop in terms of helping to prevent breaches to cancer wait times, tackle inequity and deliver improved outcomes.

**Baseline assessment of the early detection and awareness interventions using the template below will support the overall strategy**

<table>
<thead>
<tr>
<th>Draft template - Early detection and awareness</th>
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<tbody>
<tr>
<td><strong>Intervention</strong></td>
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<tr>
<td>Rapid access clinics for high risk populations</td>
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<tr>
<td>Bladder and kidney cancer – over 50s</td>
</tr>
<tr>
<td>Oesophageal and gastric cancer – over 50s</td>
</tr>
<tr>
<td>Raise population awareness of specific signs and symptoms</td>
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<tr>
<td>Utilising healthcare touch points</td>
</tr>
<tr>
<td>Roll out of the Cancer Decision Support tool</td>
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</table>
### Managing procedures in community settings: skin lesion excision

### Development of best practice pathways

### Continual learning – Primary Care

### Practice profiles

#### Recommendations

- Continue investment in national Be Clear on Cancer campaigns which have shown to be effective in increasing referral rates ([Public Health England](https://www.gov.uk/government/organisations/public-health-england))

- Explore contractual levers with dentistry and pharmacy that can be used to increase cancer awareness messaging and sign posting ([NHS England](https://www.england.nhs.uk/))

- Invest in GP cancer leads that provide local leadership and co-ordination for early detection activities, supported by a programme of training with monitoring, audit and peer review for compliance ([CCGs](https://www.england.nhs.uk/))

- Continued investment in GP early detection training and expansion of the programme to include practice nurses ([NHS England](https://www.england.nhs.uk/))

- Include cancer early detection and awareness in GP Registrar training ([CCGs](https://www.england.nhs.uk/))

- Continued partnership working with Macmillan to identify and implement cancer service improvement opportunities ([CCGs](https://www.england.nhs.uk/) and [Macmillan](https://www.macmillan.org.uk/))

- Include cancer early detection and awareness in the CCGs’ user involvement programme e.g. local Patient Partnership Group (PPG) particularly the promotion of Be Clear on Cancer Campaigns ([CCGs](https://www.england.nhs.uk/))

- Commission best practice guidance and ensure consistency across the county ([CCGs](https://www.england.nhs.uk/))

- Ensure equity of access across the county ([CCGs](https://www.england.nhs.uk/))

- Ensure improved uptake and appropriate use of Direct Access ([CCGs and providers](https://www.england.nhs.uk/))

- Integrate cancer audit activities with broader processes for audit and appraisal e.g. 2week wait utilisation and conversions ([CCGs and providers](https://www.england.nhs.uk/))

- Encourage improved access to screening programmes, e.g. peer to peer support at GP level to review uptake of cervical screening and share best practice; endorsement of bowel and breast screening by the patient’s GP to those who have not taken up the screening offer ([CCGs](https://www.england.nhs.uk/))
7. Commissioning for Outcomes – Prompt High Quality Treatment

It is vital that NGH as the lead provider for cancer is able to maintain the critical mass to ensure it delivers quality services including patients within the KGH catchment. Most patients pathways in the north of the county start at KGH – regardless of wherever the pathway starts there needs to be seamless transition of services/care between providers. To enable this Nene CCG and Corby CCG are supporting an Oncology alliance with University Hospital Leicester. This will not only support the quality and outcomes but also address gaps in the workforce.

The aim and objective of Oncology alliance is to have formal arrangements with the alignment of services to Healthier Northamptonshire, clinical and financial sustainability and resilience. Delivery of pathways may vary in terms of population to capacity and capability locally. The Oncology alliance will lead to new models of care such as preoperative work up locally with operations at Leicester and local follow up for some specialties.

As a county we have not been able to consistently deliver the national 62 day target. Key reasons for this are challenges around capacity and pathway management. Closer working between the CCGs and providers to effectively manage capacity will ensure appropriate referrals in to providers and appropriate follow ups in primary and community care for stable patients.

Management of cancer pathways should also be aligned to the CCGs’ strategy to ensure that Patients are seen in the Right Place at the Right Time by improving crisis management working with key stakeholder e.g. links to Collaborative Care Team (CCT)/Macmillan to develop better crisis management to help plan care and treatment which may help to reduce emergency admissions. Also ensure alignment to the Care Closer to Home strategy e.g. reducing secondary care follow ups for stable Prostate Specific Antigen (PSA) prostate cancer patients.

Recommendations

- Commission along best practice pathways in order to reduce variation and improve overall quality i.e. Right Place at the Right Time linked to the CCGs Care Closer to Home strategy (CCGs)

- Commission East Midlands Strategic Clinical Network pathways with acknowledgement to appropriate national guidelines to ensure standard pathways across the county (CCGs)

- Work closely with NHS England on the commissioning of the various elements of the 62 days referral to treatment pathway (CCGs and NHS England)

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22 (Cancer patients in Crisis, Responding to Urgent Need Royal College General Practitioners [RCGP] and Royal College of Radiologists [RCR] 2012)
• Closer working between the CCG and providers to effectively manage capacity (CCGs and Providers)

• Ensure all providers reach Improving Outcomes Guidance (IOG) compliance through effective performance management of contracts (CCGs)

• Commission along the Royal College General Practitioners (RCGP) and Royal College of Radiologists (RCR) recommendations to achieve the [faster] reporting time for diagnostic tests (CCGs)

• Address cancer patients also presenting with chemotherapy and radiotherapy complications i.e. implement guidelines on AOS (CCGs)

• Continue to invest in the National Cancer Patient Experience Survey (CPES) (NHS England and Macmillan)

• Ensure that improvement work as identified by the CPES is prioritised and supported (NHS England, Macmillan and CCGs)

Reconfiguration of services for rarer cancers

• Support the development of plans on the proposed tri-hospital Oncology alliance to align services to Healthier Northamptonshire to achieve sustainability and resilience (CCGs)

8. The National Cancer Patient Experience Survey (CPES)

Each year more than 60,000 patients (70,141 in 2014) in England take part in a Cancer Patient Experience survey (CPES). This level of response has been consistent through the years (since its introduction in 2010) and shows how patients value this survey and understand the importance of their voice in driving change and improvement.

The national report shows areas to concentrate on as follows:

• Improving care and survival for patients with rarer cancers, who in some cases report poorer quality care

• Improving care for patients entering through the emergency treatment route, and minimising the numbers who do so

• Improving the transition point to community care after acute treatment

• Being sensitive to the particular needs of patients with a recurrence of cancer, or where tumours have not responded to treatment as had been hoped

• Maximising the support available from Clinical Nurse Specialists, given the substantial evidence now available linking their presence to good care as seen by the patient
• Supporting those Trusts whose services have not improved in line with developments in the best performing areas

KGH and NGH receive local detailed analysis and patient comments from Quality Health (who run the survey on behalf of NHs England). From this output, work will be focussed in areas where improvement is most required.

For KGH, scores amongst the **lowest-scoring 20% of Trusts** in 2014 for the questions in the survey as numbered below are as follows:

- Q25 Hospital staff gave information about support groups
- Q30 Taking part in cancer research discussed with patient
- Q37 Got understandable answers to important questions all/most of the time
- Q62 Doctor had the right notes and other documentation with them
- Q70 Patient’s rating of care ‘excellent’/ ‘very good’

And where they were amongst the **highest-scoring 20% of Trusts**:

- Q1 Saw GP once/twice before being told had to go to hospital
- Q2 Patient thought they were seen as soon as necessary
- Q4 Patient’s health got better or remained about the same while waiting
- Q22 Patient finds it easy to contact their CNS
- Q28 Hospital staff told patient they could get free prescriptions
- Q46 Patient never thought they were given conflicting information
- Q47 All staff asked patient what name they preferred to be called by
- Q49 Always given enough privacy when being examined or treated
- Q52 Always treated with respect and dignity by staff
- Q58 Staff definitely did everything to control side effects of chemotherapy

For NGH, scores amongst the **lowest-scoring 20% of Trusts in 2014** for the questions in the survey as numbered below are as follows:

- Q1 Saw GP once/twice before being told had to go to hospital
- Q31 Patient has taken part in cancer research
- Q38 Patient had confidence and trust in all doctors treating them
- Q54 Staff told patient who to contact if worried post discharge
- Q65 Hospital and community staff always worked well together

And where they were amongst the **highest-scoring 20% of Trusts**:

- Q8 Given easy to understand written information about test
- Q14 Patient given written information about the type of cancer they had
- Q18 Patient given written information about side effects
- Q29 Patient has seen information about cancer research in the hospital
- Q59 Staff definitely did everything they could to help control pain
• Q63 GP given enough information about patient`s condition and treatment

**Recommendations**

• Ensure that improvement work as identified by the CPES and other patient surveys is prioritised and supported *(NHS England, Macmillan and CCGs)*

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### 9. Specialised Services

Specialised services are those services provided in relatively few hospitals, to catchment populations of more than one million people. The number of patients accessing these services is small, and a critical mass of patients is needed in each treatment centre in order to achieve the best outcomes and maintain the clinical competence of staff. These services tend to be located in specialist hospital Trusts in major towns and cities. Concentrating service in this way ensures that specialist staff can be more easily recruited and their training maintained. It is also more cost-effective and makes the best use of resources such as high tech equipment and staff expertise.

Delivering integrated end to end seamless pathways improves patient outcomes and experience and is also a very efficient model of care. To do this the CCGs will need to work closely with NHS England on the commissioning of the various elements of healthcare services.

**Recommendations**

• Work closely/ co-commission with NHS England to ensure integrated seamless pathways e.g. 62 day referral to treatment (RTT) national target *(CCGs/ NHS England)*

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### 10. Living with and beyond Cancer (Survivorship)

There are more than 17,500 patients in Northamptonshire living with or beyond cancer and, using national assumptions; this figure is predicated to double by 2030. With improvements in early detection and rapid advances in treatment, we should expect even larger numbers of people living with and beyond cancer, and greater numbers of people acting as carers for people with cancer.

**One year survival rates**

For Nene CCG, one-year cancer survival for all cancers is 67% (for people diagnosed in 2011) compared to the England average of 68% (see below).

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24 National Cancer Intelligence Network – Cancer Commissioning Toolkit
One year survival rates for all cancers in Nene CCG (measured by one-year net survival rates for breast, lung and colorectal cancer for ages 15 to 99) are significantly lower when compared with rates for other cluster CCGs\(^25\). See appendices 2, 3 and 4.

For Corby CCG, one-year cancer survival is 68% (for people diagnosed in 2011)\(^26\). This is similar to the England average of 68% (see below).

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\(^{25}\) Public Health Cancer Briefing for Nene CCG Feb 2015
\(^{26}\) National Cancer Intelligence Network – Cancer Commissioning Toolkit
One-year survival rates for all cancers in Corby CCG (measured by one-year net survival rates for breast, lung and colorectal cancer for ages 15 to 99) are significantly lower when compared with rates for other CCGs\(^\text{27}\). See appendices 2, 3 and 4.

**Longer term strategy will be to shift appropriate follow ups from secondary care into the community settings** leveraging on Multidisciplinary and Multispecialty clinics as outlined in NHS England 5 year Forward View.

Elements of the National Cancer Survivorship Initiative are commissioned by different organisations – CCGs, NHS England (Specialist commissioning and Primary Care contracting) and local authorities. Many elements are commissioned by NHS commissioners – e.g. stratified pathways, but local authorities have a role to play in health and wellbeing, due to their public health responsibilities.

Supporting people recovering from a cancer episode, or living with recurrent episodes of cancer, is nowadays comparable to other long term conditions albeit with cancer-specific interventions still required. Additionally certain cancer treatments can increase the risk of long term conditions such as heart disease, osteoporosis or a second cancer, and can add to other acute and chronic conditions. There will also be a need to support the increasing numbers of carers looking after family members and loved ones so that they are equipped both physically and psychologically to provide care.

The Department of Health, in partnership with Macmillan Cancer Support, published the National Cancer Survivorship Initiative (NCSI): Living with and beyond cancer: taking action to improve outcomes in March 2013. This sets out a clear framework for supporting the increasing numbers of people living with and after cancer. To improve the care and support for the current Northamptonshire patients living with cancer, recommendations follow the framework set out in the 2013 document.

We will continue to build on the CCGs strategy of developing partnership with the Third sector e.g. Macmillan, Prostate UK, Cancer Research UK and most recently Northampton Carers association.

**10.1 The Recovery Package**

One of the most important building blocks for achieving good outcomes is the Recovery Package.

Elements of the National Cancer Survivorship Initiative-recommended Recovery Package are commissioned by different commissioners – CCGs, NHS England and local authorities. Many elements are commissioned by NHS commissioners – e.g. stratified pathways - but local...
authorities have a role to play in health and wellbeing, due to their public health responsibilities.

The Recovery Package is made up of the following elements:

- a Holistic Needs Assessment (HNA) and care planning at key points of the care pathway
- a Treatment Summary completed following treatment, then shared with the person living with cancer and sent to their GP
- a Cancer Care Review completed by the GP or practice nurse to discuss the person’s needs. The review should happen within six months of the GP practice being notified that the person has a cancer diagnosis. It should be the start of an ongoing conversation required across the cancer care pathway
- an education and support event, such as a Health and Wellbeing Clinic, to prepare the person for the transition to supported self-management. The event should include advice on the relevant consequences of treatment and the recognition of issues, as well as details of who to contact. It should also provide information and support about work and finance, healthy lifestyles and physical activity

The Recovery Package also compliments the introduction of stratified care pathways which enable individualised follow-up care. This can either be through a supported self-management approach, with rapid access back into the specialist team should this be needed, or through continued face-to-face follow up with health care professionals.

A Health and Wellbeing Clinic is a crucial part of supporting not only stratification of care pathways but also ensuring people feel well supported during a period of transition between ending treatment and finding their ‘new normal’. A Health and Wellbeing Clinic may be used to improve the level of support within the existing care pathway or as part of stratification of care pathways.

10.2 Stratified pathways for the follow-up of cancer patients

The National Cancer Survivorship Initiative recommends that, following initial treatment, all patients should be assessed for their risk of developing further disease or consequences of treatment, i.e. be risk-stratified. This risk stratification will identify those who can safely self-manage without the need to attend hospital-based follow up appointments.

Supporting patients to self-manage their own health and wellbeing can meet unmet needs, reduce demand on services and so reduce costs through removing a number of follow up outpatient appointments. The elements of the Recovery Package will need to be in place so that patients are equipped to self-manage and are signposted as to where they can go for both local support services and for surveillance and access to specialists should they have any concerns. Joint plans between local authorities, primary care and secondary care will be needed as the numbers increase to ensure that patients are provided good overall support.
Improving the consistency of stratified pathways should assist in improving patient experience since they enable each patient greater choice in how their care and follow up is managed. The estimated net saving in England is £86 million, or £214,000 per 100,000 population.\(^{28}\)

It is also an opportunity to promote health and wellbeing as patients are often open to ideas to improve their ongoing health. Potential to work with the local authority around promoting health; e.g. signposting to health walks, stop smoking services. Scope for reiterating the importance of engaging with prevention activities e.g. screening (where appropriate) and immunisation (particularly important for those following chemotherapy who may have lost previous immunities).

Risk Stratified pathways have been developed in several tumour groups by the Expert Clinical Advisory Groups (ECAGs). These are included in clinical guidelines for each tumour group, e.g. risk stratified pathways exist for breast, colorectal and skin with gynaecology being developed. The CCGs will have a role to play in ensuring these are followed.

### 10.3 The Cancer Care Review

The Cancer Care Review (CCR) plays an important part in the living with and beyond cancer agenda and, as such, needs to be developed and improved. The Quality and Outcomes Framework (QoF) requires all patients diagnosed with cancer to receive a CCR by their GP within six months of the GP practice being notified that the person has a cancer diagnosis.

The Quality Outcomes Framework (QoF) lacked clarity surrounding what the CCR should consist of and what is helpful and necessary to include. As a result the patient experience is variable.

The National Cancer Survivorship Initiative (NCSI) has worked with Macmillan Cancer Support in the development of a CCR template to improve the quality and delivery of the CCR.

Routine one to five-year follow-up of cancer survivors within the NHS costs in the region of £250 million per year out of a £6 billion per year budget. This is currently delivered through a mainly medical model using consultant outpatient appointments and associated diagnostic tests. The case for routine follow-up as an effective method to pick up early recurrence or disease progression is not strong.

For lower-risk patients, a stronger emphasis on holistic care planning to sustain recovery, manage the consequences of treatment and reduce the risk of recurrence should be affordable without compromising early recurrence detection; indeed it may even improve this.

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\(^{28}\) Stratified cancer pathways: redesigning services for those living with or beyond cancer. Quality & Productivity: Prouven Case Study (2013)
Recommendations

- Increase and continue engagement with third sector and patient support group (CCGs)

- Continue the roll-out of the Recovery Package, expanding coverage and uptake, moving from Holistic Needs Assessment, Care Plan and Treatment Summary, to include all aspects of the Recovery Package (CCGs, NHS England and Macmillan)

- Review current cancer service provision, with new efforts made to redesign pathways moving away from medical model where applicable (CCGs and Macmillan)

- Commission along stratified pathways, recognising their dependency on the availability of the Recovery Package (CCGs)

- Support managed follow up and or discharges of cancer survivors to key workers and teams in the community setting (CCGs and Macmillan)

- Develop plans to reduce crisis admissions for cancer patients (CCGs and Macmillan)

- Consider how cancer support and follow-up can be integrated with the on-going management of other long term conditions (CCGs, Public Health England and NHS England)

- Improve the quality and delivery of the Cancer Care Review (CCGs)

11. End of Life Care

Too many patients do not die in their preferred place of care.

End of Life CCG profiles for 2010-12 indicate that 38% of Nene CCG cancer patients and 35% of Corby CCG cancer patients die in hospital. 29

An end of life strategy has been developed by the Northamptonshire end of life collaborative. The vision for End of Life care in Northamptonshire is:

“Compassionate care provided in a consistent, coordinated way by providers who are competent and confident in delivering high quality care. Patients enabled and supported to live and die in a place their choice”.

The strategy is based on the five priorities for the care of the dying person, developed by the Leadership Alliance for the Care of Dying People in the document, ‘One chance to get it right – Improving peoples experience of care in the last few days and hours of life’ (LACDP, 2014). The aim is to support decision making, planning and delivery of compassionate high

29 Public Health England (PHE) published End of Life CCG Profiles by CCG for 2010-12 on 28th April 2014
quality, individualised care for people who it is thought may die within the next few days or hours.

The principles supporting the strategy for end of life services for adults are:

- To be holistic (i.e. meeting physical, social, spiritual and psychological needs) and patient centred with coordinated care;

- To include support for carers both during the period at the patient’s end of life and after death;

- In the main requiring ‘generalist’ palliative care support augmented by ‘specialist palliative care’ team support where necessary; and

- Governed by one set of standards and delivered through one set of policies, pathways and protocols but reflect the differing needs of patients.

Ultimately this is to achieve an increase in the numbers of people dying in their preferred place of care, for the majority of whom this will mean at home or in a care/nursing home.

11.1 Proactive Care

Each GP practice has a Proactive care register of patients who need regular review and may be in the last few weeks or months of life. Meetings, involving members of the acute multidisciplinary team, are held regularly to discuss and communicate changes in the patient’s condition or management. The aim is to ensure best supportive care and to anticipate, and where possible, prevent crises for the patient and his/her carers.

A template should be completed by secondary care clinicians communicating a change in the management, from active to palliative intent, or condition of patients, to the primary care team in a timely manner, without waiting for a full clinical summary to be completed.

### Recommendations

- Cancer aligned to the CCGs’ end of life strategy particularly around avoiding inappropriate admission to hospital where the patient’s preferred place of care is home ([CCGs and Macmillan](#))

- Rollout of proactive care form/ EoL template to support management of patients in primary care at end of active treatment ([CCGs and Macmillan](#))
12. Conclusion

Cancer is a key priority for the NHS in Northamptonshire. Whilst there are pockets of excellence, there are also areas of wide variation in early detection, access to cancer treatment and services, standards of care, support offered following a cancer episode and at the end of life.

The strategy is to consistently deliver quality sustainable services focussed around the patient across the county working with key partners and the patients/public.
## Appendix 1 Distribution list for comment

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<td>Sue Marsden</td>
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Appendix 2 Commissioning for Value Pack – Breast Cancer pathway

Each indicator is shown as the percentage difference from the average of the 10 CCGs most similar to you. The indicators are colour coded to help you see if your CCG has ‘better’ (green) or ‘worse’ (red) values than your peers. The blue bars are used where it has not been possible to make a judgement either way so requires local interpretation. For example, high prevalence may reflect that a CCG does truly have more patients with a certain condition, but it may reflect that the CCG has better processes in place to identify and record prevalence in primary care, or that registers have not been audited recently.
Appendix 3 Commissioning for Value Pack – Lower GI pathway

Each indicator is shown as the percentage difference from the average of the 10 CCGs most similar to you. The indicators are colour coded to help you see if your CCG has ‘better’ (green) or ‘worse’ (red) values than your peers. The blue bars are used where it has not been possible to make a judgement either way so requires local interpretation. For example, high prevalence may reflect that a CCG does truly have more patients with a certain condition, but it may reflect that the CCG has better processes in place to identify and record prevalence in primary care, or that registers have not been audited recently.
Appendix 4 Commissioning for Value Pack – Lung Cancer pathway
Each indicator is shown as the percentage difference from the average of the 10 CCGs most similar to you. The indicators are colour coded to help you see if your CCG has ‘better’ (green) or ‘worse’ (red) values than your peers. The blue bars are used where it has not been possible to make a judgement either way so requires local interpretation. For example, high prevalence may reflect that a CCG does truly have more patients with a certain condition, but it may reflect that the CCG has better processes in place to identify and record prevalence in primary care, or that registers have not been audited recently.

NICE guidance:
http://pathways.nice.org.uk/pathway/lung-cancer

Public Health
England
RightCare
NHS
England

Initial contact to end of treatment

NHS Corby CCG

NHS Nene CCG

Initial contact to end of treatment
Appendix 5 High Level Action Plan

The Cancer Commissioning Strategy for Northamptonshire 2015-17 highlights a number of actions as follows:

**Primary Care**
- Robust engagement and communication of the strategy leveraging on business as usual events/activities e.g. Locality Boards, Protected Learning Time
- Develop and utilise teachable moments and by exploring funding from the third sector e.g. Macmillan/ Cancer Research UK
- Working with Public Health to mitigate at risk factors - enhanced prevention
- Reduce variation in screening and its uptake rates in hard to reach groups
- Leverage and engage on national cancer awareness campaigns
- Robust plans around early detection activities
- Audit and learning using cancer data packs - practice profiles, 2ww conversion/detection range, peer review.
- Effectively manage people recovering from a cancer episode, or living with recurrent episodes of cancer
- Ensure appropriate and improved use of Direct Access across the county
- Practices supported to reduce crisis admissions

**Secondary Care**
- Two-way communication (primary and secondary care) to look at how pathways can be improved
- Standard pathways across the county - equity for all patients regardless of where care is delivered
- Adopt best practice pathways as developed by the East Midlands Clinical Network
- Build on the Oncology alliance between KGH, NGH and UHL to facilitate delivery of the 62day RTT target
- Improve the quality of services e.g. CQUIN for electronic Holistic Needs Assessments
- Feedback to primary care on appropriate use of Direct Access
- Rollout Recovery Package to support the living with & beyond cancer & supported discharge to primary care
- Reduction in face to face contacts through telephone follow ups e.g. stable Prostate Specific Antigen project as appropriate
- Improve services to support reduction in crisis admissions e.g. Community Lung project
- Collaborative working with primary care to support proactive care of patients at end of active treatment
- Closer working between the CCGs and providers to effectively manage capacity

**Supporting Patients and the Public**
- Leverage on national cancer awareness campaigns to inform and educate
- Involve patients/public in service improvement initiatives working with organisations such as Healthwatch; Patient congress and locality engagement groups
- Ensure issues raised through patient/ carer/ family feedback are addressed
- Explore opportunities to work with Public Health, Macmillan and other third sector organisations