Key messages for Cancer Commissioners

Introduction

The aim of this short briefing paper is to assist Commissioners in deciding priorities for cancer services. It represents the priorities that have been identified by Cancer Research UK across cancer prevention, early detection and treatment based on a rigorous evaluation of the evidence and discussion with cancer experts. We fully endorse the advice to Commissioners from the Cancer Director Professor Sir Mike Richards and the two documents should be seen as complementary. Wherever possible we have provided links to key guidance. The briefing is also available on our website. We intend to update this briefing once the new NHS landscape is better understood and so we would welcome feedback on it, especially how we can make it more helpful to you in your work going forward. Please email all comments to publicaffairs@cancer.org.uk.

Table of contents

1. Cancer prevention.................................................................................................................. 1
   Tobacco control..................................................................................................................... 2
   Obesity, diet and physical activity......................................................................................... 3
   Alcohol .................................................................................................................................. 4
   UV exposure and skin cancer ............................................................................................... 5
2. Awareness and early diagnosis............................................................................................. 6
   Access to diagnostics.......................................................................................................... 7
3. Screening............................................................................................................................... 7
   Breast screening................................................................................................................... 7
   Cervical screening .............................................................................................................. 8
   Bowel cancer screening ......................................................................................................... 9
   Prostate cancer risk management programme (PCRMP) ...................................................... 9
4. Cancer surgery .................................................................................................................... 10
5. Radiotherapy ....................................................................................................................... 11
6. Chemotherapy .................................................................................................................... 12
7. Research .............................................................................................................................. 13
8. Information for patients ..................................................................................................... 14
9. Patient experience............................................................................................................... 15

1. Cancer prevention

Lifestyle choices affect our risk of developing cancer. It is estimated that over 40% of all cancers are attributable to both lifestyle choices and the environment. More than 30% of cancers diagnosed in the UK last year could have been prevented by people adopting healthy lifestyles such as:

- Stopping smoking: as smoking is the major preventable risk factor for cancer, causing around one in five cancer deaths, dissuading people from starting to smoke and helping people to quit remain crucial cancer prevention strategies. It is estimated that 23% of cancers in men and 15.6% of cancers in women are attributable to tobacco consumption.
- Avoiding obesity by eating a healthy diet and undertaking a moderate level of physical activity: obesity is one of the most important preventable risk factors for cancer in non-smokers. Those
who are obese are more likely to develop cancer and to die from cancer. It is estimated that 4.1% of cancers in men, and 6.9% of cancer in women are attributable to overweight and obesity. A further 6.1% of cancers in men and 3.4% of cancers in women are attributable to not getting enough fruit and vegetables in their diets.

- Avoiding an excessive alcohol intake: increased alcohol consumption is linked with an increased risk of several types of cancer. Alongside obesity it is one of the most important preventable causes of cancers. It is estimated that 4.6% of cancers in men and 3.3% of cancers in women are caused by excessive alcohol intake.
- Avoiding excessive exposure to UV: the incidence of skin cancer is rising and most skin cancers are linked to excessive UV exposure. It is estimated that 3.5% of cancers in men and 3.6% of cancers in women are attributable to sunbeds and excessive sun exposure.

Action to increase awareness of these risk factors and encourage people to adopt healthy lifestyles therefore plays a crucial part in tackling cancer in England. A range of well-evidenced interventions exist particularly for smoking cessation and skin cancer prevention that represent excellent value for money.

Secondary cancer prevention also has the potential to save many lives and is good value for money. During or after a cancer experience there are ‘teachable moments’ when lifestyle advice is likely to be well received. There is a growing body of evidence that physical activity supports rehabilitation, for example after breast cancer treatment.

**Tobacco Control**

Commissioners should:

- Monitor stop smoking services using key performance indicators including: four week quit rates; the proportion of these self-reported quitters validated by carbon monoxide (CO) monitoring; and targets set for service throughput.
- Form – or be an active member of – a local tobacco control alliance that brings together partners including the NHS, local government, enforcement agencies including trading standards, and local business.
- Work across local boundaries with neighbouring areas to maximise the cost effectiveness of work on mass media and marketing, countering smuggling and collecting data.

The NHS will continue to have a key role in public health when local government is in the lead, both as part of the Health and Wellbeing Board and through its own services especially:

- Brief interventions by health care professionals to encourage people to stop smoking.
- Stop smoking services in secondary care to encourage quitting and help improve a range of clinical outcomes.

**Rationale:** 80,000 people die from tobacco related diseases in England each year including cancer, heart disease, stroke and respiratory disease, more than the next six most common causes of
preventable death. Therefore preventing uptake and helping smokers quit are key public health measures.

NHS Stop Smoking Services are available to all smokers free of charge across England. Smokers who use NHS support together with quitting aids are up to four times more likely to quit successfully than those trying to go it alone. Advice and support for quitting are also available to smokers through NHS helplines and websites. Over 384,000 people successfully quit using NHS Stop Smoking Services in 2010/11.

Tobacco control measures (www.ash.org.uk/localtoolkit) like stop smoking services are very cost effective.

The Government in its Tobacco Plan for England 2011 (www.bit.ly/tobaccoplan) recommends that local areas adopt a comprehensive approach by joining up health, local government, the police and other services, with senior level accountability.

Experience of reducing tobacco use shows that, with funded coordination, areas can:

- Enhance compliance with tobacco legislation on underage sales and smuggled tobacco.
- Provide high quality and accessible local stop smoking services while developing a clear understanding among frontline NHS staff of the benefits of supporting smokers to quit.
- Develop a co-ordinated local communication strategy to encourage smokers to quit or not to smoke in front of children.

In the South West, North West and North East, health bodies joined together to fulfil these functions. The longest established body, Fresh in the North East, had smoking rates of 29% in 2005 when it was launched. By 2009 prevalence had fallen to 21%. Across England, each 1% fall in smoking prevalence can be expected to prevent some 3000 deaths per year.

### Obesity, diet and physical activity

Commissioners should:

- Liaise with public health colleagues in local authorities and with Health and Wellbeing Boards on cancer prevention.
- Identify existing obesity care pathways, or work to develop new ones taking account of NICE guidance (www.bit.ly/obesityguidance). These local care pathways will set out the various weight management services available and any associated eligibility criteria, which are often dependent on the individual’s weight status and health needs. These services have been commissioned by PCTs, ensuring relevance to local circumstances.
- Take care when entering into agreements with commercial companies to ensure that no conflicts of interest arise, and ensure that all joint working is transparent with clearly articulated aims and roles. The corporate sector can be a useful ally in implementing programmes but not in setting policy.
**Rationale:** Obesity is a major risk factor for cancer and with 60% of adults overweight or obese, supporting and enabling individuals to lose weight and prevent weight gain and regain is an important public health goal. Being obese increases the risk of many cancers, especially cancers of the uterus, kidney, colon, gallbladder and oesophagus. It is also linked to breast cancer in post-menopausal women. There will be an estimated 11 million more obese people in the UK by 2030 if current trends continue and an extra 130,000 cases of cancer over the next two decades as a result.

Preventative and management services can provide vital support to individuals at risk of gaining weight or classified as overweight or obese, helping them to reach and maintain a healthy weight.

Physical activity is an independent risk factor for a number of cancers: a person physically active at the levels recommended by the Chief Medical Officer has a 50% lower risk of colon cancer and a 20% lower risk of breast cancer ([www.bit.ly/activityreport](http://www.bit.ly/activityreport)).

*Let’s Get Moving* is a national behaviour change intervention available to the NHS and based on NICE public health guidance ([www.bit.ly/physicalactivityguidance](http://www.bit.ly/physicalactivityguidance)) which endorses brief interventions in physical activity as being clinically and cost effective, in both the short and the very long term.

### Alcohol

Commissioners should:

- Liaise with public health colleagues in local authorities and with Health and Wellbeing boards on cancer prevention.
- In accordance with NICE guidance ensure that a local joint alcohol needs assessment is carried out and ensure that integrated care pathways for alcohol treatment have been defined.
- Identify those at risk of alcohol related problems or those whose health is being harmed by alcohol and intervene where appropriate.
- Work with the corporate sector to consider joint ways of implementing programmes to reduce alcohol consumption, ensuring that commercial companies play a role in implementation rather than policy making, and that all joint working is transparent and free of conflicts of interest.

**Rationale:** Research shows that the more a person drinks the greater the risk is of developing cancer. Over the last decade, mouth cancer has become more common and this could be attributed to higher levels of drinking. Alcohol can increase the risk of cancers at levels far too low to make the average person drunk. As little as 3 units a day can increase the risk of mouth, throat, oesophageal and bowel cancers ([http://1.usa.gov/srUZ0I](http://1.usa.gov/srUZ0I)). Moreover, 2 units a day has been shown to increase the risk of breast cancer in women ([http://bit.ly/rqtZ6P](http://bit.ly/rqtZ6P)).

There is low awareness among the general public of the link between alcohol and cancer. Greater information about the cancer risks posed by alcohol and what constitutes a safe level of alcohol consumption to minimise the risk could help to reduce drinking.
Strategies should balance the need to tackle binge drinking with the need to address sustained drinking across the population. Reducing the availability and restricting the marketing of alcohol in an area through partnership working could reduce the overall consumption of alcohol.

**UV exposure and skin cancer**

<table>
<thead>
<tr>
<th>Commissioners should:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Continue to develop, deliver and maintain campaigns to raise awareness of the risk of UV exposure and ways of protecting against it.</td>
</tr>
<tr>
<td>• Aim wherever possible to adapt campaign messages from existing national health promotion programmes or services for local use, in order to keep costs as low as possible.</td>
</tr>
<tr>
<td>• Work with local authorities to ensure that sunbed salons provide appropriate educational messages about the risks of skin cancer and enforce legislation to prohibit under-18s from using sunbeds.</td>
</tr>
</tbody>
</table>

*Rationale:* There are two main types of skin cancer - non-melanoma and malignant melanoma. Non-melanoma skin cancer is thought to account for around a third of all cancers detected in the UK, with an estimated 100,000 people affected. Malignant melanoma is the most serious, and causes the majority of skin cancer deaths - around 2,500 per year. It is estimated that the NHS spends approximately £70 million on skin cancer treatment each year ([http://bit.ly/v2vqgh](http://bit.ly/v2vqgh)). The main cause of skin cancer is exposure to ultraviolet (UV) radiation from the sun and artificially from sunbeds and lamps.

Prolonged exposure can significantly increase the risk of developing skin cancer. NICE public health guidance ([www.bit.ly/sunprotectionguidance](www.bit.ly/sunprotectionguidance)) encourages a balanced approach, helping to ensure that skin cancer prevention activities do not discourage outdoor physical activity, while encouraging people to use sensible skin protection.

The guidance focuses on how the NHS and local authorities can help prevent skin cancer using public information, sun protection resources and by making changes to the natural and built environment.
2. **Awareness and early diagnosis**

Commissioners should:

Work closely with Health and Wellbeing Boards in order to:

- Gather information from relevant sources as appropriate, including:
  - Patients – their knowledge, attitudes and experience of cancer (National Cancer Patient Experience Survey [www.bit.ly/NCPEsurvey]).
  - Cancer data – (National Cancer Intelligence Network [NCIN] [www.ncin.org.uk]; Cancer Commissioning Toolkit [CCT] [www.bit.ly/cancercommissioning])
  - Outcome and process measures linked to cancer and early diagnosis – GP practice profiles and commissioner profiles and any local audit of cancer diagnosis in primary care.
  - The local community – PCT profiles (and in future local authority/Health and Wellbeing Board cancer profiles).
- Understand local diagnosis, treatment and care for cancer patients, including:
  - Key providers in public health, primary care and secondary care, as well as services delivered by the voluntary sector and other independent providers.
  - Patient pathways for common and rare cancers.
  - The local cancer network, including Network Site Specific Groups.
- Establish and maintain a range of approaches from public awareness campaigns to system changes in primary and secondary care to achieve earlier diagnosis of cancer.
- Ensure programmes have effective clinical leadership (public health and general practice, working closely with hospital clinicians) and be of sufficient scale to improve outcomes in cancer survival.
- Develop innovative public and professional awareness campaigns of the signs and symptoms of cancer to encourage earlier presentation across the whole population but especially targeting the over-50s and socially disadvantaged groups.
- Ensure accurate targeting and rigorous evaluation of interventions and co-ordination with other public health initiatives.

**Rationale:** It is estimated that up to 10,000 deaths could be avoided each year if we diagnosed cancer earlier and ensured access to appropriate treatment, and if survival in the UK matched the highest in Europe.

A key reason why our cancer outcomes lag behind the best performing countries in Europe is low public awareness of the signs and symptoms of cancer, delays in people presenting to their doctors, and patients having more advanced disease at diagnosis. People over 50 and those in socially disadvantaged groups are particularly at risk of delay (http://bit.ly/sZSxHH). Nearly a quarter of all cancers are diagnosed through an emergency route (http://bit.ly/cytG9b).

The biggest gains will be obtained by increasing the proportion of patients who are first diagnosed with an earlier stage cancer that will respond better to treatment designed to control the disease locally.
To monitor progress on early diagnosis it is essential that Trusts should report stage at diagnosis to the cancer registry.

Early diagnosis of cancer can often mean the difference between early death and long term survival or cure. Initiatives to promote earlier diagnosis are likely to be highly cost-effective (eg costs per QALY may range from £2000 to £6000).

The new cancer strategy (www.bit.ly/improvingoutcomes) which was published in January 2011 sets the aim of saving an additional 5000 lives each year from cancer by 2014/15. This means that a Clinical Commissioning Group serving a population of 200,000 will need to save 20 additional lives each year. Early diagnosis will be essential if this is to be achieved.

**Access to diagnostics**

*The Operating Framework for the NHS in England 2011/12 (www.bit.ly/operatingframework)* asked Commissioners and providers to make adequate provision for the four priority areas for diagnostics for improving earlier diagnosis of cancer:

- Chest X-ray to support the diagnosis of lung cancer
- Non-obstetric ultrasound to support diagnosis of ovarian cancer
- Flexi sigmoidoscopy/colonoscopy to support the diagnosis of colorectal cancer
- MRI to support the diagnosis of brain cancer.

**3. Screening**

Cancer screening remains an important way to detect cancer early and in some cases prevent it such as screening for cervical cancer and for bowel cancer. Over 5% of all cancers are currently diagnosed via screening, but this is set to rise as the extensions to the breast and bowel screening programmes progress. Around a third of breast cancers are now diagnosed through screening. However some groups and communities are still not accessing these services.

**Breast screening**

Commissioners should:

- Ensure that all screening services continue to take part in the breast screening age extension randomisation project, either screening women aged 47-49 or 71-73 depending on the randomisation protocol.
- Ensure that programmes should move to direct digital x-ray for breast screening as running both film and digital systems together is inefficient.
- Aim to improve communications about screening to women locally, and identify ways to increase access.
- Develop local strategies to address inequalities in access, based on the needs of the local population.
Rationale: One in eight women will develop breast cancer during their lifetime. Most of the women who get breast cancer have had their menopause, but about 20% of those diagnosed each year are under 50 years old.

The NHS Breast Screening Programme is currently being extended to women aged 47-49 and 71-73 in a project where services are randomised to one age extension or the other. The randomisation will run over two three-year screening rounds rather than one. This will save an estimated £12m per year.

It is known that older women often delay presentation of breast cancer and an improved awareness of their increased risk could address both attendance at screening and early presentation of symptoms. Women from black and minority ethnic groups are also known to participate less in screening, as are women from more deprived social groups.

Cervical screening

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 communication materials.
- Ensure that cervical screening results continue to be received within 14 days (The Operating Framework for the NHS in England 2011/12 [www.bit.ly/operatingframework]). By taking a complete screening pathway approach, achieving a 14 day turnaround time has also been shown to save an average of £100,000 per unit per year.
- Work with their local services and the NHS Cancer Screening Programme to triage HPV testing for women with mild or borderline results, which it has been shown will lead to a more patient centred service and major cost savings.
- Review messages about HPV and cervical cancer, bearing in mind that the mothers of girls eligible for vaccination will be in the age range for cervical screening.

Rationale: Cervical screening is not a test for cancer but for abnormalities which, if left undetected and untreated, may develop into cancer. Within the NHS Cervical Screening Programme in England, women aged 25-49 are invited for free cervical screening every three years and women aged 50-64 every five years. Women over 64 are invited if their previous three tests were not clear or if they have never been screened.

HPV vaccination for girls aged 12-13 was introduced in September 2008 and a catch up programme for 17-year olds and girls over 13 at the start of the programme has also resulted in a considerable number of girls being vaccinated. 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 as triage for women with mild or borderline cervical screening test results has been piloted and shown to be effective.
Bowel cancer screening

Commissioners should:

- Aim to improve the communication of the benefits of bowel cancer screening in the local community, and identify ways to increase access and uptake.
- Develop local strategies to address inequalities in access, including between men and women, based on the needs of the local population.

**Rationale:** Full roll out of the original NHS Bowel Cancer Screening Programme for 60-69 years olds (using the Faecal Occult Blood test [FOBt]) was completed in July 2010 with 100% coverage of PCT populations. The NHS Bowel Cancer Screening Programme is currently being extended to men and women from age 70 to their 75th birthday.

Flexible sigmoidoscopy (FS) is an alternative and complementary bowel screening methodology to FOBt. Evidence shows a one-off screening test for bowel cancer for men and women aged 55 can reduce population mortality from the disease by 43% and reduce incidence of bowel cancer by 33%.

*Improving Outcomes: a strategy for cancer* ([www.bit.ly/improvingoutcomes](http://www.bit.ly/improvingoutcomes)) sets out how the DH has committed to invest £60m to incorporate FS into the current bowel screening programme. Pilots are beginning in 2012 with the aim of achieving 30% coverage by the end of 2013/14 and 60% by the end of 2014/15. It is envisaged that full roll-out will be achieved in 2016.

**Prostate cancer risk management programme (PCRMP)**

Commissioners should:

- Ensure that local GPs are aware of and are utilising the information provided by the PCRMP. They should also ensure that local laboratories providing testing for the local population are using tests that conform to national standards and are applying the nationally recommended, evidence-based and age-related referral guidance ([www.bit.ly/prostateprogramme](http://www.bit.ly/prostateprogramme)).
- Aim to improve communication and awareness about the existence, risks and benefits of PCRMP to enable men to make an informed choice.

**Rationale:** Prostate cancer is the most common cancer in men. The disease mainly affects men over the age of 50 and risk increases with age. There is no national screening programme for prostate cancer because of the risks of over-diagnosis and over-treatment associated with the PSA test.

UK Government policy states that all men are entitled to make an informed decision about whether they should have the PSA test based on balanced information about its pros and cons.
4. **Cancer surgery**

<table>
<thead>
<tr>
<th>Commissioners should ensure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Appropriate levels of centralisation so that surgeons are sufficiently experienced.</td>
</tr>
<tr>
<td>• Access to the latest surgical technologies and procedures and capacity for training the workforce in these areas.</td>
</tr>
<tr>
<td>• Surgery is available whenever it is needed along the patient pathway – from prevention, to treatment, to palliation.</td>
</tr>
<tr>
<td>• Surgery for all appropriate patients is based on their physical status rather than their age.</td>
</tr>
<tr>
<td>• Accurate and robust clinical data and participation in audit.</td>
</tr>
</tbody>
</table>

**Rationale:** Advances in surgical techniques and centralisation of complex surgery mean that the quality of cancer surgery has improved with more operations being carried out by specialist surgeons with expertise in particular procedures, resulting in better outcomes, less invasive procedures, and shorter recovery times.

Improvements in early diagnosis of cancer, combined with the impact of rising incidence mean that demands for surgical oncology are likely to increase and this needs to be carefully planned for.

Surgery is an important part of cancer treatment. Surgery is not just a curative treatment. Other functions include to prevent or reduce the risk of cancer (for example using mastectomy to prevent breast cancer), to control symptoms of cancer or extend life (for example to reduce bowel obstruction in an incurable bowel cancer) or to reconstruct a part of the body affected by cancer.

Other surgical procedures provide a vital part of treatment, for example inserting a central line for chemotherapy. Because of the variety of uses, commissioning for surgery is needed at various stages of the patient pathway and for different populations.

The benefits of surgery are clear. It improves survival and reduces the costs of the ongoing treatment of cancer which progresses. Less invasive surgery – for example laparoscopic procedures - provide better value by reducing hospital stay, rates of complication and recovery time.

There is evidence of variation in access to surgery. Access to major resection varies according to geographical location and age. Access to the latest surgical technologies also varies. It is important that services providing surgical treatment participate in audit and submit robust data to monitor and seek to address this variation.

We know that patients do better when they are treated in specialist centres. Centralisation of complex surgery means that operations can be carried out by surgeons with expertise and experience in that particular area. It is important that this is considered when commissioning surgery.

In order to deliver improved access to high quality surgery, the NHS needs to:
- Promote the uptake of the latest surgical techniques, ensuring that the existing surgical workforce receives appropriate training to do this.
- Reduce regional variation rates in access to surgery; and
- Improve intervention rates for older people who could benefit, ensuring that age alone is never a barrier to the most appropriate treatment.

5. **Radiotherapy**

<table>
<thead>
<tr>
<th>Commissioners should ensure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Sufficient capacity to deliver radiotherapy in a timely manner to all patients with cancer who require it.</td>
</tr>
<tr>
<td>- Access to the most appropriate radiotherapy treatments for patients, including intensity modulated radiotherapy, image guided radiotherapy and stereotactic radiotherapy.</td>
</tr>
<tr>
<td>- A clear plan for service development to account for increases in the prevalence of cancer and the introduction of new radiotherapy treatments and technologies. At a minimum this should include a workforce plan and the replacement of radiotherapy equipment.</td>
</tr>
<tr>
<td>- Benchmarking and future planning for the services.</td>
</tr>
<tr>
<td>- Patients whose clinicians believe they would benefit from proton beam therapy have access to referral abroad for treatment.</td>
</tr>
</tbody>
</table>

*Rationale:* Radiotherapy is involved in 40 per cent of cases where cancer is cured. Radiotherapy is highly cost effective, consuming only five per cent of the NHS’s annual cancer spend.

Access to radiotherapy is critical to improving outcomes, and to improve outcomes from radiotherapy there must be equitable access to high quality, safe, timely, protocol-driven quality-controlled services focused around patients’ needs.

Detailed modelling suggests that 52% of cancer patients should receive radiotherapy as part of their treatment, although recent work suggests this figure may be lower. Patients should be offered the most appropriate radiotherapy choice for their cancer, which may involve treatments such as intensity modulated radiotherapy and image guided radiotherapy.

Good information is essential as a way of benchmarking access to radiotherapy services. The Radiotherapy Data Set (RTDS) will be routinely published to ensure that commissioners and providers have benchmarked data about their performance.

Radiotherapy treatments such as intensity modulated radiotherapy and image guided radiotherapy provide more targeted treatment, further reducing side effects and improving outcomes for patients. Investment in service development in recent years has meant that improvements have been made in both waiting and travelling times for patients.

Continued investment is needed to ensure that the latest developments in radiotherapy can be translated quickly into clinical practice. The delivery of radiotherapy services is highly reliant on an adequate and highly trained workforce.
Low access rates are thought to be attributable in part to a lack of awareness of the benefits of radiotherapy and a lack of availability of the latest radiotherapy treatments. This may mean that clinicians are not referring some patients for treatment who may be suitable for radiotherapy, or that patients may be opting for treatments other than radiotherapy when given a choice.

Commissioners should develop local plans to ensure that access rates to radiotherapy - and the use of advanced radiotherapy techniques such as IMRT - are appropriate for their populations.

Commissioners should also work with providers to prepare for the implementation of a tariff for radiotherapy in 2013.

For more information on radiotherapy, please see the National Radiotherapy Awareness Initiative document, Radiotherapy: an introduction for commissioners and providers.

6. Chemotherapy

Commissioners should ensure that:

- Patients who might benefit from chemotherapy are able to access quality services.
- Treatments that are delivered are appropriate to a patient’s condition.
- Services are delivered safely.
- Services are convenient for patients.
- Patient experience is good.
- Services represent good value for money.

*Rationale:* The use of systemic anti-cancer therapy has increased markedly over the past decade. There is evidence that the UK is a relatively low user of some cancer drugs and that patients may be treated more conservatively than in other countries.

Advances in knowledge of genetics and biochemical pathways are now being translated into new targeted medicines. This means that drugs will be able to be targeted at smaller groups of patients with a particular genetic characteristic, enabling efficacy, more accurate dosing and sparing patients who will not benefit from possible side effects.

Improving the quality and safety of chemotherapy services can make an important contribution to delivering the patient safety domain of the NHS Outcomes Framework 2011/12 ([www.bit.ly/NHSoutcomes](http://www.bit.ly/NHSoutcomes)). Commissioners 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. They will also need to take account of current processes in place locally around the administration of the Cancer Drug Fund.

Commissioners may wish to use financial incentives and contractual arrangements to improve quality and choice to encourage reductions in emergency admissions and to reward improvements in patient experience. To achieve this, Commissioners may wish to set requirements about the
introduction of e-prescribing, door-to-needle time for patients with neutropenic sepsis and acute oncology services.

The National Chemotherapy Action Group (NCAG) report (www.bit.ly/NCAGreport) provides best practice guidance for commissioners of chemotherapy services. The report sets out a framework for planning, implementing and monitoring services based on a care pathway model and proposed actions that need to be taken by Commissioners and providers to ensure high quality care.

Commissioners should work together across a cancer network to plan, procure and monitor service delivery. They should ensure that acute oncology services (AOSs) are available in all hospitals with A&E departments. If chemotherapy is given elsewhere, Commissioners should ensure that there are appropriate arrangements in place for patients to access telephone advice and emergency care. They will wish to achieve an appropriate balance between centralisation and localisation and to ensure that all services deliver safe and effective treatment in line with NCAG guidance.

Commissioners across the network should ensure that they have sufficient expert advice to guide their commissioning in this high cost, complex area. Investment in expertise will lead to savings from the rationalisation of chemotherapy provision and reduced complications from chemotherapy treatment.

Commissioners should work with providers to prepare for the implementation of a tariff in 2012/13. This will require a year of shadow running against their current contracting methodology, followed by a year of using local costs applied to the national Healthcare Resource Group (HRG) framework, before the full tariff is implemented.

7. Research

Commissioners should:

- Ensure the provision of treatment costs for patients participating in research are met through commissioning budgets.
- Consider whether the service delivers research activity, based on recruitment levels of patients to studies.
- Identify need within patient populations for access to research studies, and align this need with commissioned services.
- Work with the national commissioning structures to deliver innovation of care pathways, processes and interventions.

**Rationale:** Clinical research studies in the NHS are vital in cancer research, whether they are epidemiological studies or clinical trials of interventions. Research conducted in the NHS has supported many breakthroughs in cancer treatment and service design. In the UK one in every six cancer patients is involved in research, representing 42,000 cancer patients per year, the highest level in the world.

Patients involved in clinical trials gain early access to innovative medicines, devices, procedures or diagnostic techniques. Patients also benefit from increased monitoring, access to leading research-
active experts, one-to-one care from experienced research nurses, improved information and better continuity of care.

We also know that patients treated in research-active environments have improved clinical outcomes, and that research-active healthcare systems deliver better care.

It is vital that patients across the country are able to participate in clinical trials on the NHS, and that commissioning for services to enable access to clinical trials is considered alongside other patient pathway decisions. The Government has committed all parts of the NHS to promoting and supporting research, including a commitment for Clinical Commissioning Groups to have a duty to promote research and innovation.

8. Information for patients

Commissioners should ensure:

- High quality and evidence-based information is available for all patients across the entire pathway
- That information is endorsed as accurate, relevant and up to date by an accreditation system, such as the ‘Information Standard’ ([http://bit.ly/40Bkdu](http://bit.ly/40Bkdu)).
- Information is available in different formats (print, online, multi-media, translated and through advocates such as CNSs) according to patient requirements
- The availability of information about research and clinical trials and how to participate
- Information is regularly updated in line with changes in guidelines or advances in treatments.
- Patients and relatives are signposted to independent information resources (for example, charity websites and helplines) that they can access for information at times other than when they are in hospital.
- The routine availability of high quality national information on all cancer types through tools such as the Information Prescriptions system ([www.nhs.uk/ips](http://www.nhs.uk/ips)).

**Rationale**: Cancer care is complex. There is a wide range of services available to patients with cancer and navigating these services can be challenging. Information for patients does not just relate to diagnosis and treatment but relates to all aspects of care planning, aftercare, finances and emotional issues. It also includes information on performance differences in cancer care such as changes in survival, surgical resection rates and emergency admissions.

High quality information for patients should be available all along the patient pathway. It should be easily accessible in a variety of formats and should provide patients with the opportunity to share experience with others and give details of local support services relevant to them. Information given to patients should aim to empower them and inform choice on all aspects of care, from choices about prevention of cancer and healthy lifestyle through to treatment choices or care at the end of life. Consideration should also be given to ensuring relatives and carers have access to information that assists and empowers them. The National Cancer Patient Experience Survey has shown that provision of information varies between cancer types and at different stages of the patient pathway.
Information prescriptions can be used as a source of key information on conditions, services and care that is seamlessly and formally integrated into the care process. They provide a way for organisations to meet patients’ rights to information to support choice and to enable people to be involved in discussions and decisions about their care.

9. Patient experience

Commissioners should:
- Monitor trusts’ Patient Experience Survey results and ensure improvements on measures in relevant areas

Rationale: The National Cancer Patient Experience Survey provides insights into the experience of cancer patients and provides trust level data on performance. These data can be used to maintain standards and improve patient experience where necessary.