SUMMARY:

As a recommendation of the London-wide Model of Care for Cancer Services, the NHS cancer care providers of North East London, North Central London and West Essex are working together in an integrated cancer system known as London Cancer. London Cancer’s aim is to drive superior outcomes and experience for patients.

London Cancer has developed a case for change for specialist urological cancer pathways. The CCG has been asked to comment on the proposed change to Urology cancer pathways. This is the first of several cancer pathway reviews that London cancer will carry out.

The paper also provides an opportunity to update the CCG Governing Body on the commissioning of cancer services in general.

SUPPORTING PAPERS:

Supporting papers available on request:
Appendix 5.2a: Urological cancers: the case for change
Appendix 5.2b: Specialist urological cancer centres – the clinical evidence to support the case for change

RECOMMENDED ACTION:

The Governing Body is asked to:

• **NOTE** the new commissioning systems for cancer and
• **APPROVE** and comment on the proposed changes to the urology pathway for London Cancer providers in North Central London, North East London and the City, and West Essex.
**GOVERNANCE:**

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<td>Dr Mo Akmal</td>
<td>Secondary Care Representative</td>
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**Objective(s) / Plans supported by this paper**

The cancer commissioning intentions summarised below, and the proposal for urological cancer pathways, are consistent with national and local objectives to improve outcomes for patients with cancer. Evidence on clinical effectiveness has been used to provide guidance to consolidate some specialist surgical operations at hospital sites with sufficient numbers to maximise outcomes.

Cancer is in all of the 5 domains of the NHS outcomes framework.

**Audit Trail**
The London Cancer proposals have been sent, via respective Clusters, to all CCGs in North Central London (NCL), North East London (NEL), West Essex and South Hertfordshire with a request for views.

The proposals are also being discussed with Joint Health Overview and Scrutiny Committees. The proposals have been publicised in Islington CCG’s GP newsletter and a NCL/NEL clinical workshop is scheduled for 12 March 2013.

The urology pathway changes were discussed widely with providers, patients and commissioners in development.

**Patient & Public Involvement (PPI):**
Patients are members of the Urology pathway board and Cancer Joint Development Group. Patients are also represented on different London Cancer pathway boards.

To ensure commissioners understand a wide range of views prior to finalising the clinical recommendations, NHS NCL and NHS NEL are engaging with patient and public representatives, local councils, local involvement networks and other groups between February and March 2013. Representatives are also attending local patient group meetings to gain feedback on the proposals.

**Equality Impact Assessment:**
An equalities impact assessment is being undertaken on the proposals. A copy of the final report will be shared with CCGs

**Risks:**
Risks relate are to patients outside Islington travelling longer distances to have some surgical treatments.

London Cancer is leading work with patient representatives to consider travel mitigations.

**Resource Implications**
Any resource implications will be presented to the NHS Commissioning Board as part of decision making.

**Next Steps:**
Following engagement with patient and public representatives, CCGs and Health Overview and Scrutiny Committees and other stakeholders, the outcome of engagement, clinical recommendations and implementation plans will be presented to NHS Commissioning Board London for decisions.
1. Executive Summary
The CCG has been asked to comment on the proposed change to Urology cancer pathways. There is the first of several cancer pathway reviews that will be undertaken by London Cancer.

The paper also provides an opportunity to update the Governing Body on the outline of commissioning of cancer services in general.

2. Cancer needs for Islington
This section provides a brief overview of the need for cancer services in Islington:

- Cancer morbidity and mortality remains high in Islington. 330 people die each year from cancer in Islington. Lung, bowel and breast are the commonest causes of cancer death in Islington.
- Cancer is the biggest cause of premature death (under 75 years) in Islington and second highest cause of death overall.
- Islington has a significantly higher mortality rate (premature and all age) than London and England.
- Islington has the highest incidence of cancer amongst CCGs in London. This is partly from higher smoking rates that were later to fall, than other areas, but also low public awareness and late presentation.
- 670 people in Islington per year (2007-09) are diagnosed with cancer.
- Islington PCT carried out a review of needs re cancer for a public health annual report in 2008.

3. Cancer commissioning systems
Presently CCGs in north central London and north east London work together to commission cancer services, mainly via commissioning pathways. The commissioning model is based on the London case for change and model of care from 2009/10.

London Cancer brings together all the providers in north central London, north east London and West Essex, who together work with commissioners including primary care cancer leads, to agree and provide best evidenced pathways. London Cancer Alliance represents providers in west and south London.

3.1. Commissioning systems from April 2013
This is evolving ready for April 2013, as the cancer commissioning team at NHS North Central London finishes at the end of March 2013.

From April 2013 the NHS Commissioning Board (NHSCB), CCGs and public health will commission cancer services and will need to work together across patient pathways.

3.2. Cancer Prevention
Prevention remains very important, as up to 43% of cancers are preventable and late presentation remains a problem in Islington. Commissioning of prevention is mainly with public health from April 2013 (with CCG involvement) including smoking cessation.
3.3. Cancer Screening
The Department of Health (DH) will continue to set the strategy and policy for screening.

Public Health England will carry out those functions for screening best carried out nationally:
- Advising on service specifications and Quality Assurance (QA) standards
- Managing piloting of extensions to programmes, and providing expert Public Health analysis and advice to NHSCB
- Providing expert health analysis to the Department of Health and NHS CB
- Supporting expert advisory committees

NHS CB will be responsible for commissioning screening services for London.

Public health, CCGs and GPs will continue to have some targets for delivering cancer screening.

3.4. Cancer Earlier Diagnosis
There has been national and local work to aim for earlier diagnosis, as it is known that outcomes for patients with cancer in the UK are not always as good as some parts of Europe, in part because of later diagnosis.

It is known from the 2009 national RCGP audit, carried out nationally and in Islington, that the delays in diagnosis are often due to patients not presenting early enough for investigation.

To promote earlier presentation and diagnosis there have been campaigns such as “Be clear on cancer” for lung and bowel cancer, as well as ovarian cancer and abnormal bleeding. Initial evidence shows greater knowledge in the public of when to seek help after the campaigns, as indicated by the Cancer Awareness Measure (CAM) and more cancer referrals. Whether the campaigns have led to cancer being diagnosed earlier and at a more treatable stage will be evaluated and will inform the national decisions re future campaigns.

Local work with community groups in support of the earlier diagnosis has been led by public health.

Public health with CANCER UK has funded a cancer facilitator, Anne-Marie Love, to work with practices on practice systems to support earlier diagnosis from February 2013. The January 2013 CCG practice education event focused on earlier diagnosis of cancer.

3.5. Cancer diagnostics
As we try to diagnose cancer earlier, more of “query” cancer tests will be ordered by primary care, before a 2 week cancer referral when appropriate.

CCGs commission diagnostics, including the overall 6 week maximum wait target for tests. The 2-week maximum wait target for diagnostic that may lead to a diagnosis for cancer is met locally for blood tests e.g. PSA for prostate cancer, CA125 for ovarian cancer and Chest X-rays, but is not always met for ultrasounds and MRI brain scans.
It is an aspiration, but not yet a national target that urgent gastroscopies are done within 2 weeks.

3.6. Cancer pathways for diagnosis and treatment
Clinical Commissioning Groups (CCGs) will commission services for patients with the following cancers, with the exception of radiotherapy, chemotherapy and specialist interventions

- Bladder and kidney cancer (except specialist surgery)
- Breast cancer
- Germ cell cancer (initial diagnosis and treatment)
- Gynaecological cancers (Initial assessment of all cancers; treatment of early stage cervical and endometrial cancers)
- Haematological cancers and associated haemato-oncological pathology
- Lower gastrointestinal cancer
- Lung cancer (including pleural mesothelioma)
- Prostate cancer (except specialist surgery)
- Sarcoma (soft tissue where local surgery is appropriate)
- Skin cancer (except for patients with invasive skin cancer and those with cutaneous skin lymphomas).

CCGs will need to work collaboratively across the Northeast London Commissioning Support Unit (CSU) and London Cancer area.

3.7. Specialist commissioning will commission the following:

- All care provided by Specialist Cancer Centres for specified rare cancers e.g. Brain, Anal,
- Complex surgery for specified common cancers provided by Specialist Cancer Centres e.g. Gynaecology, Urological
- Certain specified interventions provided by specified Specialist Cancer Centres e.g. Thoracic surgery for Lung cancer
- Radiotherapy service (all ages)
- Chemotherapy: for specified rare cancers, the procurement and delivery of chemotherapy including drug costs
- Chemotherapy: for common cancers, the drug costs, procurement and delivery of chemotherapy.

3.8. What tools are available to help commissioning cancer pathways?
The following tools are available in support of commissioning cancer pathways:

- **Service specifications** have been developed for all specialist services and will be part of the NHSCB’s contract with Trusts for all specialist services – 15 specifications for specialist cancer services have been developed.
- Advisory specifications for local services commissioned by CCGs for Breast, Colorectal and Lung have been developed and are available at https://www.cancertoolkit.co.uk
- These specifications are not constrained by what we have national data on, but aim to describe “What a good service looks like” and hence what should be commissioned.
- Format - schedule taken from the standard NHS Acute Services contract.
New Improvement Body (NIB) takes over the work of the National Cancer Action team.

London-wide cancer clinical senate / strategic clinical network including Barnet GP / Primary Care Cancer Lead, Dr Clare Stephens, to support CCGs and CSUs with cancer commissioning.

Northeast London Commissioning Support Unit (CSU) has commissioners specifically for cancer.

National cancer patient experience survey is carried out at all trusts annually, with action plans to improve, as London results have been disappointing.

Cancer waiting time / target data,

National audit data and Cancer registry staging and 1 year and 5 year survival data.

NICE cancer referral guidelines are used by all practices to inform referral pathways. NICE is updating these guidelines for 2014.

3.9. Survivorship after cancer

More than 50% of patients who have had cancer survive more than 5 years as survival for many cancers is improving, and 275/10,000 registered patients on GP lists have had cancer in the past.

This has led to the pathway boards and survivorship boards to consider, alongside patients and commissioners, to consider the needs of this cohort including:

- When can they be discharged to no routine hospital follow-up,
- Providing a survivorship plan on discharge, which supports the patient and the GP to know what future actions may be needed, e.g. late effects of chemotherapy, what will most aid them to live life post cancer?

This is an area of increasing research including cognitive behaviour therapy (CBT) for cancer survivors and an exercise scheme for people who have had cancer are being evaluated in Islington and elsewhere.

3.10. Supportive and palliative care

All PCTs/CCGs have carried out work to meet NICE supportive care guidance for cancer.

CCGs and NHS London have commissioned palliative care services including the local ECLIPSE palliative care service and the new internet based London MY CARE register, to help communication across services.

Dr Patrick Mcdaid continues as the palliative care facilitator for Islington and Camden practices.

Most Islington practices participate in the Local Enhanced Service (LES) for palliative care.

4. London cancer Urology pathway proposals

Clinicians from across London Cancer (North East London, North Central London and West Essex) have been working together, along with GPs and patient representatives to consider how we could deliver the best possible urological cancer care for our patients, specifically for bladder and prostate cancer, and kidney cancer.
Across the London Cancer area around two people a day require complex surgery to treat kidney, bladder or prostate cancer. These patients require highly specialist, once-in-a-lifetime surgery to give them the best chance of controlling their cancer and reducing the risk of long-term side effects such as incontinence.

We have a highly-skilled and experienced workforce, passionate and committed to delivering the best care to the populations that we serve. However, the way in which urological cancer specialist surgical services are currently arranged does not maximise delivery of the highest quality of care, research and training that we are capable of.

Clinicians from across the trusts believe that this needs to change and have developed a case for change that outlines the rationale for the proposals for staff as well as local patient and public groups and other representatives.

While London Cancer recommends improvements across the whole pathway, the changes in particular lead to specialised surgery taking place at fewer sites, to improve outcomes with greater numbers being done at any one site.

Following a designation process across providers currently delivering urological cancer surgical services across North Central London, North East London and West Essex, London Cancer is recommending to commissioners that:

Complex bladder and prostate surgery should be based at University College London Hospitals (UCLH) NHS Foundation Trust.

Complex prostate surgery is already based at UCLH for North Central London CCGs.

Complex renal cancer surgery should be based at the Royal Free London NHS Foundation Trust.

The changes, if agreed, will be implemented by April 2014.

Patients would still be able to have their initial investigations and other treatments, including some types of surgery, at their local hospital of choice. There will still be urology services at all sites in London Cancer. Quality of care would also improve across all local urological cancer units, in line with agreed standards and an audit programme.

There is evidence that some patients agree with travelling further to get better quality treatments. For Islington residents the proposed hospitals for specialist urological centres are nearby. The travel implications are greater for patients from outside North Central London. London Cancer is working with providers and patient and public representatives to consider how travel concerns could be addressed.

For fuller details of these proposals please see the case for change and clinical evidence attached to the email with the board papers. The full documentation is also available to view at http://www.londoncancer.org/cancer-professionals/urological/urology-proposals-our-process/.

5. Conclusion
The Governing Body is asked to:
• NOTE the new commissioning systems for cancer and
• APPROVE and comment on the proposed changes to the urology pathway for London Cancer providers in NCL, NELC and West Essex.