ACHIEVING WORLD-CLASS CANCER OUTCOMES

A STRATEGY FOR ENGLAND

2015 – 2020

1. The Strategy

This report by the Independent Cancer Taskforce proposes a strategy for improving radically the outcomes that the NHS delivers for patients with cancer. It provides 96 recommendations to improve the prevention, diagnosis, treatment and care of cancer in England. A summary is provided below.

2. Objectives

- An additional 30,000 patients per year surviving cancer for >10years (by 2020),1/3 of which by earlier diagnosis – closing the gap in survival rates between England and the best elsewhere
- Better integration of health and social care for the whole patient pathway and CCGs to have role in commissioning diagnostic services
- Patients better informed and involved in decisions about care, improvement in experience including end of life care (EOLC) and to include Quality of Life (QOL) measures as they are developed (e.g. Patient Reported Outcome Measures (PROMs))
- A reduction in the growth of number of people being diagnosed with cancer
- A reduction in variation in access to optimal diagnosis and treatment
- Achievement of significant savings which can be reinvested to meet rising demand and achieve improved outcomes

3. Principles

- Care should be personalised for type of cancer and needs, co-produced with the patient and meets the need for post treatment care. Spotlight on targeted groups i.e. over 75 years, Teenagers and Young Adults (TYA), patients with mental issues, patients with metastatic disease
- Individual responsibility and self-management are key aspects of care plans
- Locally delivered within national standards; local and national accountability
- Research findings to drive future improvement
- Commissioners and providers to be flexible in order to respond to latest developments

4. Performance Metrics: Cancer Dashboard

NHS England with other Arm's Length Bodies to develop a cancer dashboard of metrics by CCG and provider to track progress. Provider dashboard will include:

- Proportion of patients meeting CWT; 96% meeting 31 day target, 85% meeting 62 day target
- Cancer patient experience survey
- Data from clinical audits
- Further patient experience and quality of life measures (e.g. Patient Reported Outcome Measures PROMS)
- Proportion of patients participating in research

5. Key Strategic Priorities

- Reducing the incidence of cancer (public health measures)
- Improving survival rates (e.g. increased screening, earlier diagnosis, improved treatment)
- Improved patient experience, as important as the treatment itself (e.g. incentivising continuous improvement, addressing staff experience)
- Improving quality of life and end of life support (measuring, improved rehabilitation, return to work, and mental health and EOLC)
- Improving efficiency and effectiveness

6. Cost

- NAO estimate cancer services cost the NHS £6.7 billion p.a. 20013/14 (excluding some primary care costs, and the private and voluntary sectors)
- Five Year Forward View (FYFV) projects 9% growth p.a. So, £13 billion by 2020
- Estimated cost of strategy £400 million p.a. (£300 million may be in FYFV baseline)
- Taskforce estimate savings of £400 million p.a. in the medium term towards the projected £22bn funding gap
- A health economics approach has been recommended

7. Specific Capacity Deficits Identified

The process for gathering the information was by engaging (face to face, emails and telephone calls) internal and external stakeholders. Internally engagement was with clinical leads and MDT leads, senior nurses, pharmacy, corporate groups and operational management. Externally this was with organisations such as the Strategic Clinical Network (SCN), NHS Sheffield Clinical Commissioning Group (CCG) and Sheffield Children's Hospital (SCH).

Several of the potential implications for STH will require further refinement when additional guidance is available. Details will include additional benchmarking of current performance, metrics to inform potential costings, training implications, action planning and plans to assure implementation.

Appendix 1 – Potential Implications for STH

Recommendations, selected from the 96, which are likely to have the most direct and current impact upon the Trust**.**

Key

AHP – Allied Health Professional
AHSNs - Academic Health Science Networks
AMD(C) – Associate Medical Director Cancer
CCGs – Clinical Commissioning Groups
CNS – Cancer Nurse Specialist
COSD – Cancer Outcomes Services Dataset
CRG – Clinical Reference Group
CWT – Cancer Waiting Times
EOLC – End of Life Care
FIT - Faecal immunochemical test
FYFV Five Year Forward View
HNA – Holistic Needs Assessment
HWB – Health and Well-being Boards
IT – Information technology
LWBC –Living With and Beyond Cancer
NICE –National Institute of Clinical Excellence
PHE – Public Health England
PROMs – Patient Reported Outcomes Measures
PTC – Primary Treatment Centre
SACT - Systemic Anti-Cancer Therapy
QOL - Quality of Life
SCN –Strategic Clinical Network
TYA Teenagers and Young Adults
WTP Working Together Programme

Appendix 1 – Potential Implications for STH

The following recommendations, selected from the 96, are those which are likely to have the most direct and current impact upon the Trust**.**

No	Cancer Strategy Recommendation	Potential Issues for STH	Potential Cost Implications	STH Lead / Other Lead	External Timescale
1	NHS England, working with the other Arm's Length Bodies, should develop a cancer dashboard of metrics at the CCG and provider level, to be reported and reviewed regularly by Cancer Alliances *(see recommendation no 78).* The following metrics should be included as a minimum: **CCG Dashboard:** • Proportion of patients referred by a GP with symptoms receiving a definitive cancer diagnosis or cancer excluded within 2 and 4 weeks, with a target of 50% at 2 weeks and 95% at 4 weeks by 2020 • Proportion of diagnoses through emergency presentation • Proportion of cancers diagnosed at stage 1 or 2, with a target of 62% by 2020 for cancers staged, and an increase in the proportion of cancers staged • *Screening uptake, with an ambition of 75% for FIT in the bowel screening programme by 2020 (Bowel Screening Programme)* • One-year survival • Proportion of patients meeting cancer waiting times targets: target of 96% meeting 31 day target and 85% meeting 62 day target • CPES data • Proportion of patients with patient- agreed	Awaiting CCG dashboard. Advocate a joint approach with CCG to further this work. STH and Sheffield CCG consider influencing NHS England & Monitor to ensure that dashboard fit for all organisations and does not require local organisations to create local dashboards. STH benchmark against dashboard. STH comply with many of these targets. • Most 31/62 patients are referred to Outpatient clinics. • Although G.P.s can and do refer patients to imaging directly most patients with a suspected diagnosis of cancer are referred to outpatient clinics and seen within 2 weeks. • Where 'fast track' or 'one stop' clinics are in operation the imaging and report will be available at the time of the outpatient clinic. • If there is no 'fast track' clinic the outpatient clinician will request the imaging via ICE and a radiology appointment will be agreed with the patient during the outpatient visit. Patients are imaged within two weeks of any such referral. • Most urgent referrals from GPs or 31/62 patients are reported within two weeks. The following require clarity on the expected standards:		CCG Cancer Commissioner	Mid 2016

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	written after-treatment plan, with a target of 95% by 2020 • Under-75 mortality • *Over-75 indicator (to be developed)* • *Further patient experience and quality of life measures as they are developed, e.g. Patient Reported Outcome Measures (PROMs)* • Proportion of people who die who had a personalised end of life care plan	*FIT* (Bowel Screening programme) • *new data fields required* • *admin to input data* • *new demand on Endoscopy* • *IT input* *Over 75 indicator and Patient Reported Outcome Measures E.g.* • *additional data entry* • *additional staff resource* • *additional training* • *maintaining systems and processes*	✓ ✓	Cancer Exec Care Group Management Teams	2020 Not stated
1	**Provider Dashboard:** • Proportion of patients meeting cancer waiting times targets: target of 96% meeting 31 day target and 85% meeting 62 day target • CPES data • Data from clinical audits • Further patient experience and quality of life measures as they are developed, e.g. PROMs • Proportion of cancer patients participating in research	STH to consider a separate (to CCG) or shared dashboard. • *collation of data* • *maintenance of STH dashboard*	✓	Operations Director (OD), Cancer Management Group	Not stated
8	NHS providers should ensure that all patients treated for cancer are given advice, tailored to their individual circumstances and risk level, on how to improve their lifestyle. This advice should include healthy eating, weight control, physical activity levels, smoking cessation and alcohol consumption, to help prevent secondary cancers. This advice should be recorded in their medical notes.	Need to review of current practice to develop a more systematic approach. • consider being linked to Holistic Needs Assessment (HNA) and/or Patient Information Prescription (PIP). • produce a generic patient information leaflet. • electronic recording of HNA/PIP may require additional IT input.	✓	Lead Cancer Nurse Lead cancer CNSs IT	Dec 2016

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15	Public Health England should continue to invest in "Be Clear on Cancer" campaigns to raise awareness of possible symptoms of cancer and encourage earlier presentation to health services. Campaigns should include lung, breast over 70s, and other cancer types where pilots prove effective. PHE should also explore the use of this brand to improve uptake of screening programmes, particularly amongst disadvantaged groups. NHS England, Public Health England and the Department of Health should jointly plan campaigns to ensure an integrated roll-out across the service, with a minimum of two national campaigns each year	National campaigns drive public awareness and subsequent demand for cancer care and treatment. When campaigns are planned, early notification and consideration of the impact on relevant clinical directorates will be required. • Increased data entry and tracking • Increased demand on services • Additional capacity in treating specialties SCN liaise directly with PHE and initial feedback indicates that campaigns are planned up to 6 months in advance so earlier notification not possible. SCN highlighted the cross over in campaigns (e.g. 16 cancers running concurrently starting Feb 2016 will have an effect).	✓	Public Health England (PHE) Care Group Management Teams Cancer Exec	Ongoing
17	NHS England should mandate that GPs have direct access to key investigative tests for suspected cancer – blood tests, chest x-ray, ultrasound, MRI, CT and endoscopy – by the end of 2015.	Awaiting NHS England mandate. Currently, GPs have direct access to key STH investigative tests for suspected cancer – (blood tests, chest x-ray, ultrasound, MRI, CT and direct access flexible sigmoidoscopy service) via ICE. (NB Colonoscopy not included). If mandated, clarity of requirements and commissioning arrangements required. • clinical time • additional tests • increased demand on patient flow • additional data input	✓	NHS England CCG	End of 2015
19	NHS England should establish a national diagnostic capacity implementation fund to unlock the significant increase in diagnostic capacity required to implement higher levels of investigative testing.	Awaiting NHS England guidance. NHS England met with commissioners and providers to discuss the capacity planning work occurring and found some areas of good practice.. • Admin • IT re additional data collection	✓	NHS England Clinical Director of Medical Imaging	Not stated

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		• additional funding would be required for equipment and workforce. • workforce skill mix would need to be considered to extend the scope of practice of reporting radiographers to enable reporting turnaround targets to be met.		and Medical Physics Clinical Director of Laboratory Medicine	
23	NHS England should pilot the role of a cancer nurse specialist in large GP practices to coordinate diagnostic pathways and other aspects of cancer care.	Awaiting NHS England guidance. Consider being involved in a pilot. There is currently a mechanism to engage with CNSs in GP practices via the STH Cancer Lead Nurse with the CCG Quality Nurse.		NHS England STH Cancer Lead Nurse CCG Primary Care Nurse	Not stated
24	By the end of 2015, NHS England should develop the rules for a new metric for earlier diagnosis measurable at CCG level. Patients referred for testing by a GP, because of symptoms or clinical judgement, should either be definitively diagnosed with cancer or cancer excluded and this result should be communicated to the patient within four weeks. The ambition should be that CCGs achieve this target for 95% of patients by 2020, with 50% definitively diagnosed or cancer excluded within 2 weeks. Once this new metric is embedded, CCGs and providers should be permitted to phase out the urgent referral (2-week) pathway.	Awaiting NHS England rules for a new metric for earlier diagnosis. Could impact all existing processes and systems for tracking. Would require ground up redesign. Need to understand the impact of phasing out of GP 2ww target on the other CWT targets. STH involved in National work to determine the metrics. GP direct access imaging referrals- • All <u>urgent</u> GP Referrals are reported within two weeks and reports available on ICE. • 98% of all GP X-ray referrals are reported within two weeks. • Report turnaround times for non-urgent GP referrals for CT, MRI and Ultrasound are 80% within 4 weeks. • IT & Data input • Clinical input – reporting • Increase demand for histopathology and imaging • Admin input & training	✓	CCG Cancer Management Group Clinical Director of Medical Imaging and Medical Physics Clinical Director of Laboratory Medicine Care Group Management Teams IT	2020

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26	Clinical Reference Groups (CRGs) should regularly evaluate emerging evidence to determine whether service configuration for surgery merits further centralisation and advise NHS England accordingly. Any reconfiguration should be undertaken with regard to broader commissioning and patient experience factors.	STH will need to engage with future centralisation reviews and assess the impact of any potential change in the provision of specialised surgical services.		Associate Medical Director (Cancer) (AMD (C)) CCGs	Not stated
28	The Royal College of Surgeons of England and Royal College of Surgeons Edinburgh, working with Clinical Reference Groups, NCIN, Care Quality Commission (CQC) and Cancer Research UK, should lead a process to define, by mid-2016, key quality metrics for each cancer surgery sub-speciality. Any new data collection should start in 2016 and then be incorporated in service specifications.	Awaiting quality metrics for key cancer sub-specialities via Royal College of Surgeons of England and Royal College of Surgeons Edinburgh, working with Clinical Reference Groups, NCIN, Care Quality Commission (CQC) and Cancer Research UK. Inform cancer teams when metrics disseminated and support understanding of metrics. Consider new metrics and potential impact on IT and training of MDTs and admin. • IT input – training • IT input extra data fields • Maintaining systems	✓	To be appointed when sub-specialties are selected	Mid 2016
29	From autumn 2015, NHS England should commence a rolling programme of replacements for LINACs as they reach 10-year life, as well as technology upgrades to all LINACs in their 5th year. All LINACs that are already ten years old should be replaced by the end of 2016 at the latest. This should be driven through a national capital fund, overseen in the first 2-3 years by a small implementation team, who will also need to ensure that equipment is geographically distributed to serve local populations optimally	STH has approved plans to replace old LINACs, and the major equipment replacement plan includes the assumption of a 10-year life i.e. STH is compliant. STH to consider that if NHS England provides a national capital fund to assist Trusts with LINAC replacement, STH should consider requesting funding “Serving local populations optimally” is being addressed through the Doncaster radiotherapy satellite work and the WPH Strategy.		Exec Director of Cancer Services Clinical Director of Specialised Cancer Services	End of 2016

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30	As part of the national radiotherapy capital fund, NHS England should support the provision of dedicated MR and PET imaging facilities for radiotherapy planning in major treatment centres.	STH as a major treatment centre has dedicated provision of these services on site: • WPH- MRI images for routine radiotherapy planning. • NGH CT facility includes the capability of being able to make use of images for radiotherapy planning. • PET – Non STH provider (NGH site) STH is compliant. STH should consider requesting funding.		Exec Director of Cancer Services	Not stated
34	Monitor and NHS England should introduce new sanctions for any provider not fully complying with electronic prescribing by March 2016.	STH comply in the fact that there is a fully implemented electronic prescribing system used to prescribe all systemic anticancer therapies. The Trust has plans to implement electronic prescribing from April 2016. Systemic Anti-Cancer Therapy (SACT) data submission – STH Chemotherapy Intelligence Unit is working with Public Health England on the data fields where we do not fully comply. Review implications when sanctions published		STH Principal Pharmacist Cancer Services & Palliative care Monitor	March 2016
35	CQC should ensure that assessment processes for providers incorporate submission of data in a timely manner to Systemic Anti-Cancer Therapy (SACT).	Await CQC report. Incorporate submission of data in a timely manner to SACT.		CQC	Not stated
36	NHS commissioners should ensure that: • All patients under the age of 50 receiving a bowel cancer diagnosis are	Awaiting guidance from NHS England. NB Sheffield Genetics Diagnostic Service is provided by Sheffield Children's Hospital.		NHS commissioners	Not stated

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	offered a genetic test for Lynch Syndrome. • All women with non-mucinous epithelial ovarian cancer are offered testing for BRCA1/BRCA2 at the point of diagnosis. • All women under the age of 50 diagnosed with breast cancer are offered testing for BRCA1/BRCA2 at the point of diagnosis. These tests will enable any family members at high risk to be identified and active surveillance programmes put in place. Where applicable, positive tests should guide decisions on the most clinically and cost-effective prevention interventions or treatments.	Current situation at STH: • Bowel - all patients who have a diagnosis are offered a genetic test for Lynch Syndrome. • Ovarian - Women with non-mucinous epithelial ovarian cancer. STH do not provide this service. • Breast – STH do not offer gene testing to women under the age of 50; it is not part of NICE guidelines. (Only offer gene testing when the chances of a gene mutation is >10%). Consider discrepancy between NICE guidance and this Cancer Strategy recommendation. If STH considered these services . • increase in labs testing time • increase in labs reporting time • increase in clinical input • increase in admin input	✓	MDT and Cancer Site Lead for Bowel Cancer MDT and Cancer Site Lead for Gynae Cancer MDT and Cancer Site Lead for Breast Cancer Cancer Site Leads Sheffield Children's Hospital	
37	NHS England should transform access to molecular diagnostics to guide treatment for cancer: NHS England should nationally commission access to molecular diagnostic tests to guide treatment, starting with the following cancer types in 2016: melanoma, lung, colorectal, breast and all paediatric cancers. This would be in addition to haematological cancers, with a further broadening out to all cancer types where treatments are already subject to a molecular diagnostic test by 2020.	Awaiting guidance from NHS England. NB Sheffield Genetics Diagnostic Service is provided by Sheffield Children's Hospital. STH/SCH/Leeds hospitals have been asked to consider bidding as one regional centre due to the National reconfiguration of genetics services. STH use molecular tests in: • Breast • Lung • Melanoma		NHS England STH SCH Leeds	End 2016 guidance 2020 - implementation

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	Use of molecular diagnostic tests by providers should be added to the COSD data set. NHS England should undertake a year by year review of molecular diagnostics capacity given the pace of scientific and technological advance. NHS England should develop plans to move to a validated multiplex molecular diagnostic panel by end 2016.	STH are non-compliant with COSD. Consider if rolled out to other suggested tumour sites. Example Haematology spends on service approx. £300,000 pa. Consider integration of IT systems. . • admin capacity • additional data entry • training for data entry • costs of tests • turnaround time for tests reporting • IT infrastructure • maintenance of systems and processes	✓	Informatics Director	
38	NHS England should encourage providers to streamline MDT processes such that specialist time is focused on those cancer cases that don't follow well-established clinical pathways, with other patients being discussed more briefly.	Awaiting guidance from NHS England. STH engaged in work around MDT meeting efficiency. STH currently follow NCPR guidance.		NHS England MDT Leads AMD(C)	Report due July 2016
39	NHS England should require MDTs to review a monthly audit report of patients who have died within 30 days of active treatment, to determine whether lessons can be learned about patient safety or avoiding superfluous treatment.	Awaiting NHS England guidance. STH MDTs are expected to audit patients that have died within 30 days (monthly). Consider evidence review required from all MDTs.		NHS England AMD(C)	Not stated
40	The Trust Development Authority, Monitor and NHS England should strongly encourage the establishment of national or regional MDTs for rarer cancers where treatment options are low volume and/or high risk. Clinical Reference Groups will need to play a key role in supporting these.	Awaiting NHS England guidance. Potential impact on MDT and Consultant time supporting CRGs. If remote MDT decision making requested from STH this may be more resource intensive than at present.		The Trust Development Authority, Monitor and NHS England	Not stated

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		Trust to assess the impact of any potential changes in the provision of specialised cancer services. • Admin input • Consultant time • Video – conferencing equipment and support	✓		
41	NHS England, the Trust Development Authority and Monitor should pilot a comprehensive care pathway for older patients (aged 75 and over in the first instance). This pathway should incorporate an initial electronic health needs assessment, followed by a frailty assessment, and then a more comprehensive geriatric needs assessment if appropriate. The pilot should evaluate a model in which the outputs of these assessments are considered by the MDT in the presence of a geriatrician, who would advise on AHP needs, co-morbidities etc., and their implications for treatment and emotional and physical support.	Awaiting NHS England guidance. Surgery has an elderly person surgical pathway. Patients are discussed three times per week in presence of a geriatrician all patients over 75 and the ones needing a geriatric review are seen. Significant implication regarding cost of the frailty assessment and geriatrician input into MDT meetings. • Admin input • Consultant time with pre and post prep for MDT meeting	✓	NHS England, the Trust Development Authority and Monitor	Not stated
43	NHS England, working through the CTYA Clinical Reference Group should: • Consider whether paediatric treatment centres should be reconfigured to provide a better integrated network of care for patients and families. • Establish clear criteria for designation and de-designation of treatment centres for TYA patients. • Ensure that any transition gap between children's' and adult services is addressed. • Assess impact of proposals on travel times for families.	Await new criteria from NHS England. A potential implication for STH is that STH might not meet the new criteria, and will therefore lose Primary Treatment Centre (PTC) status for TYA patients. Sheffield is one of the smaller units, and geographically between Leeds and Nottingham, so could be at risk. Consider impact of de-designation (loss of all 16-19 year old patients to another PTC, loss of some 19-24 year olds who choose PTC over local care) would have on STH.		NHS England STH TYA Clinical Lead SCH TYA Clinical Lead	Not stated

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		STH to consider that the TYA unit is income generating for the charities linked to STH. Cross reference with WPH strategy.			
45	NHS England should ask NIHR and cancer research charities to consider ways in which access to clinical trials for teenagers and young adults with cancer could be significantly increased. NHS England should set an expectation that all Centres or designated units treating TYA patients should aim to recruit at least 50% of those patients to clinical trials by 2025.	Currently do not meet this target. Will require STH to commit to opening trials for TYA cancers. STH have agreed in principle to attempt to open the next Intergroup Hodgkin trial. This requires clinician buy in, as well as R+D support. Network subspecialty leads for the different cancer subgroups e.g. lung, breast. Opportunity to collect in COSD. Resource implication: • Admin data collection and entry		Clinical Lead Y&H STH TYA Clinical Lead SCH TYA Clinical Lead IT	
51	By the end of 2015, NHS England should publish clear guidance that commissioners must meet excess treatment costs for clinical trials accepted on to the NIHR portfolio as part of routine business. ETCs for radiotherapy trials should be distributed through a national fund held by NHS England to ensure high quality clinical trials are developed and delivered optimally.	Await NHS England to publish clear guidance. Most trials are chemotherapy or radiotherapy so under current NHS England arrangements.		NHS England	Not stated
54	NHS England should continue to commission CPES annually. It should also take steps to increase BME representation in CPES for a minimum of 1 to 2 years to understand drivers of poorer experience within these groups better. It should consider how CPES data can be linked with other datasets to understand experience across the pathway. It should also develop a methodology to collect data on patient experience for under 16s	STH complies with the current requirement of the Cancer Patient Experience Survey (CPES) (annually). Await new CPES elements of BME and under 16s from NHS England. Consider informatics strategic approach to combine multiple data sets.		NHS England Cancer Lead Nurse/ Lead Cancer CNSs Informatics Director Clinical Specialist	Not stated

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		STH are working with paediatric radiographer colleagues around the country on developing the elements of the CPES for under 16s.		Radiographer, Patient Information and Support, Children and Young People	
55	NHS England should work with Monitor, the Trust Development Authority, the Care Quality Commission and partners to develop by 2017 a metric or set of metrics that would encourage providers and commissioners to focus more consistently on improving people's experiences of their care, treatment and support. Once developed, these measures should be rolled out nationally as part of the 'cancer dashboard' and embedded in incentives and mechanisms of accountability. E.g. CQC should incorporate these measures into its assessment metrics for hospitals.	Awaiting Monitor, the Trust Development Authority, the Care Quality Commission and partners to develop the metrics by 2017. STH to establish how to collect data • increased data input • increased admin and training • adding data sets to IT infrastructure	✓	Monitor, Trust Development Authority, Care Quality Commission Informatics Director	2017
57	From confirmation of a diagnosis, all consenting patients should have the ability to access all test results and other communications involving secondary/tertiary care providers online. The aim should be to achieve this for all patients by 2020, extending to include all GP records thereafter.	Statement unclear as to what extent patient access is required. Currently GPs have access to ICE to view all results. Existing national requirement for patients to access records in Primary care. STH feed primary care results to GPs and have a requirement to communicate with GPs about patients. Do we need to be involved? STH consider as part of the Trusts strategic approach to informatics.		Informatics Director CCG	2020
60	Health Education England should review the training and support currently provided to NHS staff. It should work with Medical Royal Colleges and other bodies to ensure that all new and, where appropriate, existing staff have mandatory	Awaiting Health Education Guidance. Advanced Communication Skills Training was removed from the National Peer review Programme (NPRP) in recent years. Potential to be reinstated in		Health Education England	Not stated

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	communication skills training. This will need to include empathetic listening skills, shared decision-making, empowering patients to self-manage, and how to deliver difficult news.	the measures.			
61	NHS England and the Trust Development Authority should encourage providers to ensure that all patients have access to a CNS or other key worker from diagnosis onwards, to guide them through treatment options and ensure they receive appropriate information and support. In parallel, NHS England and Health Education England should encourage providers to work with Macmillan Cancer Support and other charities to develop and evaluate the role of support workers in enabling more patient centred care to be provided.	All cancer patients at STH are allocated a CNS/key worker from diagnosis.		Cancer Lead Nurse Cancer CNSs	Not stated
62	NHS England should encourage all hospital providers to provide a directory of local services (electronic and on paper) and facilitate local cancer support groups (e.g. by providing free space), which can provide peer and signposting support to cancer patients being treated there. This should complement directories provided in general practice.	Awaiting guidance from NHS England. A Sheffield cancer charity currently produces and regularly updates a services guide. STH CNS teams provide input. STH have an up to date support group list Updated 6 monthly. Consider how STH could facilitate cancer support groups		Manager WPH Cancer Information and Support Centre Lead Cancer Nurse Cancer Lead Nurse and Cancer CNSs	Not stated
63	The NHS and partners should drive forward a programme of work to ensure that people living with and beyond cancer are fully supported and their needs are met. This should include approaches to reducing and managing long-term consequences of treatment. This could include understanding how tested approaches such as trigger questions can be embedded into clinical practice, as well as approaches to ensuring that specialist services for complex problems arising	STH are part of the LWBC National 5 year and regional programme of work commencing April 2016. Funds available for transformational work (bidding process). Advocate a joint approach to further work with the CCG. • impact on IT of treatment summary and HNA, including training and maintenance	✓	Macmillan Consultant Nurse Lead Cancer Nurse Cancer CNSs CCG	2016-2020

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	from cancer treatment are commissioned				
64	NHS England and Public Health England should work with charities, patients and carers to develop a national metric on quality of life by 2017 which would enable better evaluation of long-term quality of life after treatment. PROMs should be rolled out across breast, colorectal and prostate cancer by 2020, with evaluation informing further rollout across other cancer types	Awaiting metrics from NHS England. • admin data entry • IT – new data fields • IT – training	✓	NHS England and Public Health England Cancer Lead Nurse Cancer CNSs in the respective sites: breast, colorectal and prostate	2017
65	NHS England should accelerate the commissioning of services for patients living with and beyond cancer, with a view to ensuring that every person with cancer has access to the elements of the Recovery Package by 2020. In addition, NHS England should work with NICE to develop a guideline, by mid-2016, for a minimum service specification, building on the Recovery Package, thereafter to be commissioned locally for all patients, together with a suite of metrics to monitor performance. This specification would be expected to evolve over time, as resources permit. Initially this specification could include the following: • A holistic needs assessment and a written individualised care and support plan at key points across the pathway. The patient should agree with and own this plan which should be shared with their GP or other designated local healthcare professional. It should take in to account social circumstances, mental health needs, and any co- morbidities.	STH are part of the Macmillan LWBC National 5 year and regional programme of work commencing April 2016. Advocate a joint approach to further work with the CCG. • IT in terms of infrastructure and training	✓	NHS England and Public Health England Cancer Lead Nurse Cancer Site Lead Clinicians Cancer CNSs Macmillan Consultant Nurse Informatics Director	2016-2020

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	• Information on likely side-effects of treatment and how best to manage these, including those that might appear after some months/years. • Potential markers of recurrence/ secondary cancers and information on what to do in these circumstances. • Key contact point for rapid re-entry if recurrence markers are experienced or if serious side effects become apparent. • A cancer care review to discuss ongoing needs and completed by the patient's GP or practice nurse. • A treatment summary completed at the end of every phase of acute treatment, sent to the patient and their GP • Access to a patient education and support event, such as a Health and Wellbeing Clinic, to prepare the person for the transition to supported self- management, including advice on healthy lifestyle and physical activity. • Signposting to rehabilitation, work and financial support services				
67	The Trust Development Authority and NHS England should ensure all providers are incentivised to start implementing stratified follow-up pathways of care for patients treated for breast cancer. NHS England should pilot stratified follow-up pathways of care for other tumour types, ideally including prostate and colorectal and some rarer cancer types, with an aim to roll out nationally for at least two other cancer types by 2020.	STH are part of the Macmillan LWBC National 5 year and regional programme of work commencing April 2016. Advocate a joint approach to further work with the CCG and the SCN. Role of Network Site Specific Groups (NSSG's) for relevant tumour sites to be addressed. • increased admin support • IT - infrastructure and training	✓	Lead Cancer Nurse and Cancer CNSs Cancer Site Lead Clinicians MDT Leads	2016-2020
75	NHS England should ensure that CCGs	Advocate a joint approach to further work with the		CCG Cancer	Not stated

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	commission appropriate integrated services for palliative and end of life care, in line with the NICE Quality Standard (2011). They should take into account the independent Choice Review and the forthcoming Ambitions for End of Life Care, working with Health and Wellbeing Boards. They should consider the role of the 'Gold Standards Framework' within their delegated powers for commissioning of primary care. CQC should incorporate end-of-life care into its assessment metrics for hospitals and other providers of cancer services	CCG. Consider IT strategy. Provision of EOLC would be considered a core service in most circumstances. There is an End Of Life Care (EOLC) group that is currently developing a Trust EOLC strategy. To underpin this clinically there are reference points and care plans in place to support staff to provide good EOLC.		commissioner and CCG GP Clinical Cancer Lead STH Palliative Care Lead	
76	By the end of 2015 NHS England should set out clear expectations for commissioning of cancer services. All commissioners should commission to NICE guidelines and CRG- approved service specifications as a minimum. The following principles should form the basis of the new cancer commissioning landscape, to be clearly defined in national guidance from NHS England: • All treatment services for rare cancers (fewer than 500 cases per annum across England, including all paediatric, teenage and young adult services) should be commissioned nationally.- *Specialised Commissioning* • Other cancer treatment services (cancer surgery where national volumes are less than 2,500 per year, all remaining radiotherapy, and all remaining chemotherapy) should be commissioned by a lead commissioner across populations of 4-5 million or more. *Y&H Specialised Commissioning* • Cancer surgery where national volumes are between 2500 and 7500 per year should be commissioned by a lead CCG commissioner	Guidance from NHS England sets out clear expectations for commissioning of cancer services, One area of commissioning not settled is with regards to cancer surgery where national volumes are between 2500 and 7500 per year. Advocate a joint approach to further work with the CCG and the WTP. • IT would be required if considered to analyse data • STH could potentially lose services	✓	Executive Director for Cancer AMD(C) CCG Cancer commissioner CCG GP Cancer Clinical Lead	2016

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	for populations of 1-2 million or more. To be explored at Working Together Programme (WTP) • Breast and colorectal cancer surgery should be commissioned at CCG level. *Commissioned* • Diagnostic services to confirm or exclude cancer should be commissioned at CCG level, including a range of blood tests, chest x-ray, ultrasound, CT, MRI, endoscopy and biopsy. *Commissioned* • Primary care services should be commissioned by NHS England Regional Teams or through CCGs via delegated responsibility where appropriate. *Delegated Co-commissioning in Sheffield of primary care from April 2016* • Services to support living with and beyond cancer, including end of life care, should be commissioned by CCGs with support from HWBs*. In the CCG work programme*				
78	NHS England should set expectations for and establish a new model for integrated Cancer Alliances at sub-regional level as owners of local metrics and the main vehicles for local service improvement and accountability in cancer. We advise that Cancer Alliances should be co-terminus with the boundaries of Academic Health Science Networks (AHSNs), although in some large AHSN geographies there may be a need for two Alliances. Alliances should be properly resourced and should draw together CCGs and encourage bimonthly dialogue with providers to oversee key metrics, address variation and ensure effective integration and optimisation of treatment and care pathways.	Awaiting NHS England guidance to establish a new model for integrated Cancer Alliances at sub-regional level. The Cancer Strategy Group South is developing the framework for the Alliance. Advocate a joint approach to further work with the CCG and the SCN.		NHS England SCN CCG	2016

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	Cancer Alliances should include local patients and carers, nurses and Allied Health Professionals.				
82	NHS England should commission a rolling programme of national clinical audits for critical cancer services, e.g. annually for lung cancer, and oversee an annual audit of cancer diagnosis.	Need clarification on the term 'critical cancer services'. STH currently collect this as part of COSD. • IT re data input and admin and training in terms of migrating all MDT audit data to COSD	✓	NHS England	Not stated