National Cancer Information Network Launch Event

Information for Commissioning Improved Outcomes from Cancer

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Aim of Session

- To put data and information into the context of commissioning improved outcomes:
  - Understanding what ‘commissioning’ is
  - Commissioning against clinically effective pathways and Map of Medicine
  - Planning, monitoring and enforcing
  - Understanding and tackling inequalities
- As a key element of the Cancer Reform Strategy's approach to strengthening commissioning, the session will explore the functionality of the new Cancer Commissioning Toolkit

Commissioning is ?

- **Identifying need**
- **Identifying demand**
- **‘Shaping the market’**
- **Holding the market to account**

(DH definitions)

Or:

- **Know exactly what you want by when**
- **Get someone else to do it**
- **Know how it will be done**
- **Cycle: plan, monitor, adjust**

(McKinsey’s view)

The Cancer Reform Strategy on Commissioning and Information

Using information to improve quality and choice (Chapter 8)

- Rationale: Better information on cancer services and outcomes will enhance quality, inform commissioning and promote choice

Stronger Commissioning (Chapter 9)

- Rationale: Stronger commissioning will drive up service quality and ensure value for money

Commissioning and Value for Money

- VFM is a definition of quality
- The three ‘E’s’
  - Effectiveness
  - Efficiency
  - Economy
- Quality is implicit in this – as is ‘knowing exactly what you want’
- In terms of outcomes but ‘process’ will remain an important predictor of outcomes
- But you can’t do this without understanding the numbers!

CRS – Action in hand to strengthen commissioning

- A guide for cancer commissioners
- An electronic commissioning toolkit
- Service specifications linked to Map of Medicine

An evidence base for commissioning quality? WHO publication ‘Purchasing to Improve Health Systems Performance’

- High quality care can be achieved when interventions that work are applied to the right patients at the right moment and at the right place
- Quality of healthcare can be improved by translating evidence from research into practice.
- Once the evidence has been systematically reviewed it must be turned into recommendations that, in turn, must be enforced.
- This is where one shifts from defining quality to purchasing [commissioning], and finally monitoring quality
- It is problematic when purchasers [commissioners] do not clarify for providers what they mean by quality and what they want providers to achieve

From Chapter 10 – Purchasing for quality of care: Velasco-Garrido, Borowitz, Ovretveit and Busse

An evidence base for commissioning quality? The role of data and information

- None of this can be done without data
- Data processed to become useful = information
- To define and clarify what is needed
- To measure what is being delivered – both in terms of process key metrics and outcomes
- Need for integrated and comprehensive information specifications – and affordable and available software solutions.
- *To plan, monitor and enforce*

Commissioning against Clinically Effective Care Pathways

- Express the quality required – know exactly what we want
- Progress on this approach in many Networks – example of NELCN:
  - 30 approved pathways together with Key Performance Indicators/Metrics – in NHS Contract 2008/09 Schedules
  - Programme Board Chaired by a patient. PCCL sits on it.
  - Localities to compare to their actual pathways, prioritise and implement changes. They remain accountable for outstanding gaps.
- CRS project for national reference pathways

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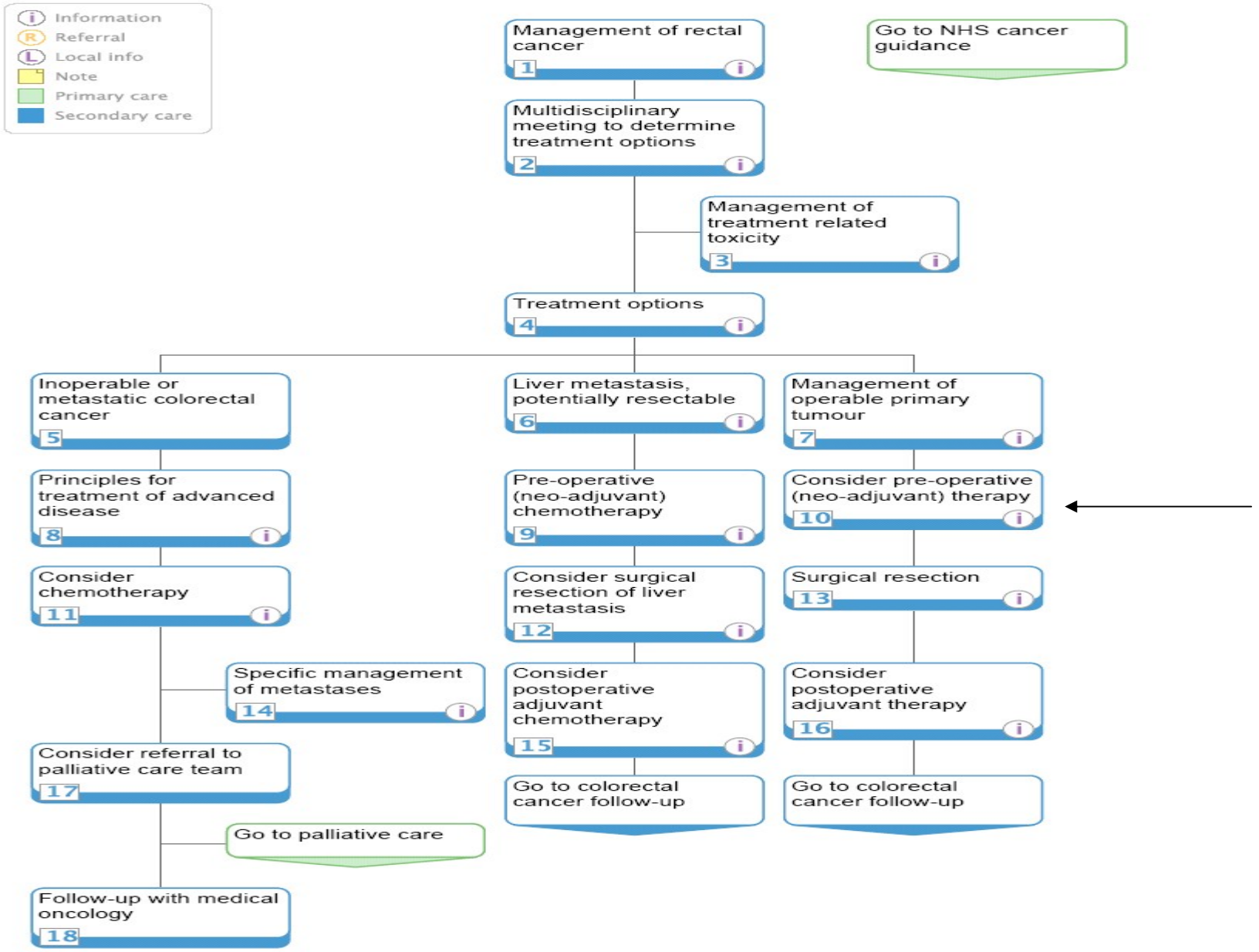
Network Development Programme Reference Pathways Project

- Project will develop national reference clinically effective pathways to support commissioning on Map of Medicine
- Colorectal has been piloted and published with roll out programme involving designated lead networks for each pathway.
- Developed and agreed with involvement of both national and local clinical leads
- Evidence based, best practice in service improvement, self improving – but references only
- The ‘key’ pathway is the one that, following the benchmark comparison, is commissioned locally.
- Further development to link to Toolkit on key indicators and service volumes and therefore costs

Rectal cancer - management

Oncology and Palliative Care > Oncology > Colorectal cancer



Rectal cancer - management

10 Consider pre-operative (neo-adjuvant) therapy

Quick info:

Pre-operative radiotherapy may be used to:

- reduce local recurrence rate and more distant metastases and also to debulk the primary tumour
- as yet, studies have not reliably demonstrated a survival benefit with pre-operative radiotherapy

Additional chemotherapy:

- no high quality guidelines or systematic reviews were found to endorse routine addition of chemotherapy to neo-adjuvant radiotherapy for rectal cancer
- however, some clinicians add low dose folinic acid and 5-FU to the pre-operative radiotherapy regimen

References:

Scottish Intercollegiate Guidelines Network (SIGN). Management of colorectal cancer. Edinburgh: SIGN; 2003.

NICE. Guidance on the use of capecitabine and tegafur with uracil for metastatic colorectal cancer. London: National Institute for Clinical Excellence; 2003.

NICE. Irinotecan, oxaliplatin and raltitrexed for the treatment of advanced colorectal cancer (review of Technology Appraisal 33). London: National Institute for Clinical Excellence; 2005.

Maxwell-Armstrong C, Scholefield J. Colorectal cancer. Clin Evid 2003; 509-17.

Glimelius B, Gronberg H, Jarhult J et al. A systematic overview of radiation therapy effects in rectal cancer. Acta Oncol 2003; 42: 476-92.

Camma C, Giunta M, Fiorica F et al. Preoperative radiotherapy for resectable rectal cancer: A meta-analysis. JAMA 2000; 284: 1008-15.

Munro AJ, Bentley AHM. Adjuvant radiotherapy in operable rectal cancer: A systematic review. Semin Colon Rectal Surg 2002; 13: 31-42.

Commissioning and tackling inequalities

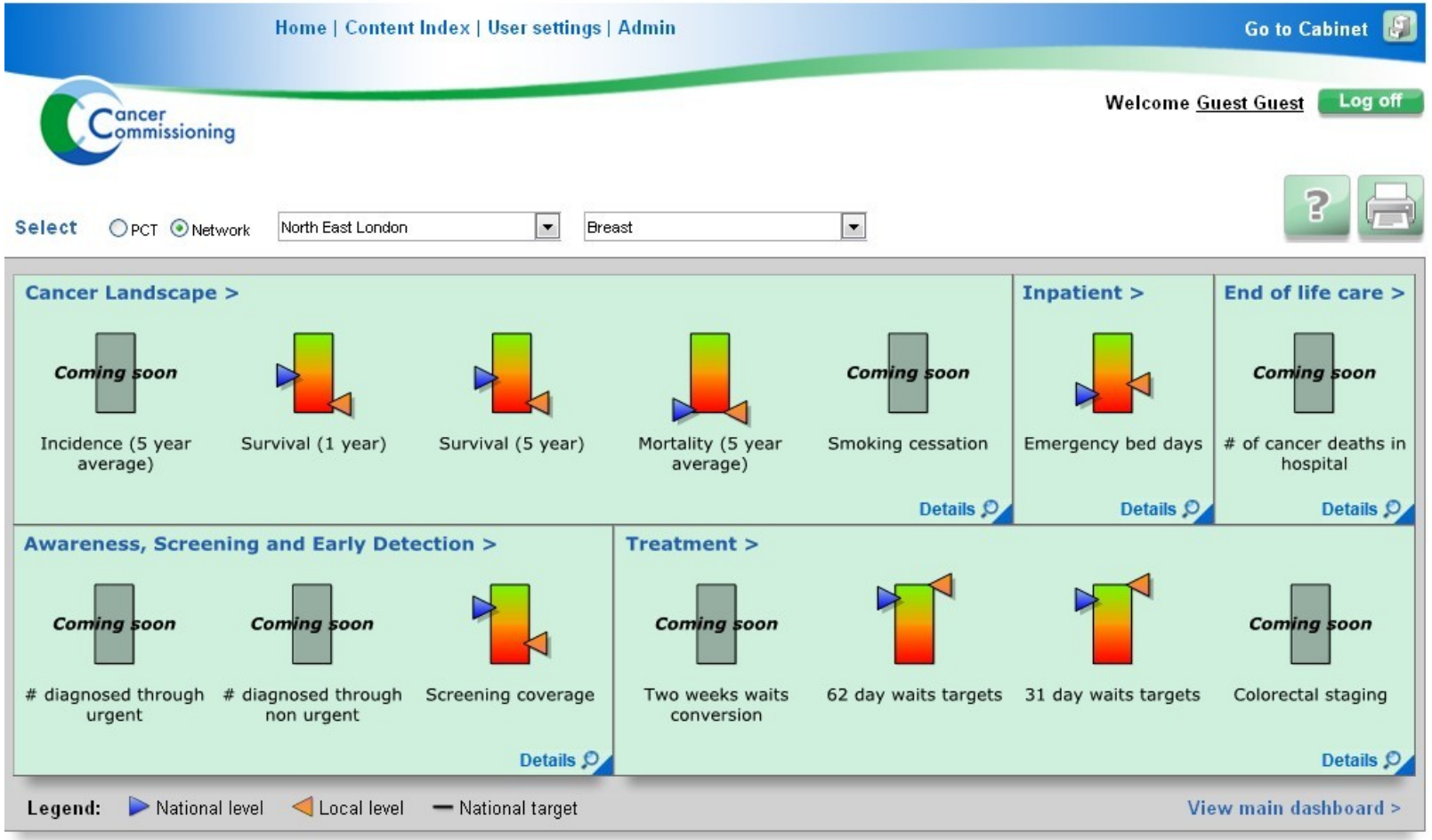
- Pathways will help us commission good outcomes ‘on average’
- CRS identifies that inequalities exist over a range of issues
- Example of NEL and poor 5 year survival for breast cancer
- Emerging initial findings indicate that, perhaps as to be expected, the position is complicated
- But that even existing historic data is rich with information if you exploit it ‘forensically’
- Investigation has turned over long held assumptions
- And highlighted the danger of working to ‘averages’ – and that inequalities may remain as a result

Breast Cancer Inequalities Board Meeting: 12th June 2008

Karen M Linklater, BSc, DipLib,
Victoria Coupland,
Elizabeth Davies

Thames Cancer Registry

What does the Toolkit say?



Transforming Data into Action

- As an example, NEL Cancer Network Board agreed in December a target of improving 5 year survival to London average by 2012
- Analysis by TCR to date is both interesting and important with implications for others on, for example, deprived populations.
- But none of this matters if we do not take actions that will change our poor outcomes
- Exercise has shown that we might otherwise have prioritised actions inappropriately
- Transforming data into action