NCIN CTYA Cancers Workshop

Making data relevant to clinical practice – who needs what?

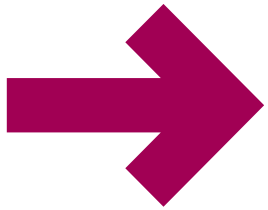
The changing commissioning landscape in England

Claire Foreman
Anthony Prudhoe

NHS England; a reminder

Single, national commissioner responsible for ensuring that services are commissioned in ways that support consistency:

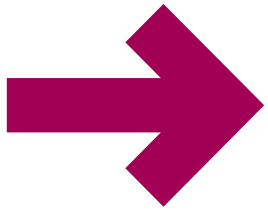
- Primary care
- Offender healthcare
- Services for the armed forces
- Specialised services
    - Implemented through **Regiona**l and **Area Teams**
    - Managed through five national **programmes of care**
    - Supported by **Clinical Reference Groups**



CRGs and contract products

Key bodies

- **Clinical Reference Group (CRG)**
  - Identifies topics for development (policy, service specification, dashboards)
- **Programme of Care (PoC) Board**
  - Provides quality assurance and ensures recommendations align with service priorities
- **Clinical Priorities Advisory Group (CPAG)**
  - Applies decision-making framework to make recommendation on priorities for investment
- **Directly Commissioned Services Committee (DCSC)**
  - Makes decision based on CPAG recommendations



Since we last met……

- New NHS Chief Executive
  Simon Stevans

- Task force for specialised services
  Now lead by Richard Jeavons Interim Director of Specialised Services
  7 Work streams

- 5 Year Forward View

- Some idea about the next steps for specialised services

Taskforce for specialised services

7 Work streams

1. Strategic projects
2. Strategy
3. Clinically driven change
4. Operational leadership
5. Commercial and technical delivery
6. Strong financial control
7. Analytics

5 Year Forward View

- Published on 23 October 2014
- Sets out how the health service needs to change, a vision of a better NHS, the steps that we should take and actions from others
- Three key messages for the NHS
  - Serious about prevention
  - New models of care
  - Efficiency and funding
  - Financial challenge (Closing the £30b gap by 2020/2021)

New care model - specialised care

- In services where the relationship between quality and patient volumes is strong, NHS England will now work with local partners to drive consolidation through a programme of three-year rolling reviews.

- We will also look to these specialised providers to develop networks of services over a geography, integrating different organisations and services around patients, using innovations such as prime contracting and/or delegated capitated budgets.

Next steps direction of travel

- The Task-force has identified that some services would be better commissioned in partnership with CCGs rather than in isolation of the local services with which they are inextricably linked.

- NHS England is going to build on the success of CCGs to date by giving them the opportunity to play a greater role in the commissioning of all health services for the populations they serve.

- **Proposals for 2015/16:**

    - Over the coming years, NHS England intends to move towards a more differentiated approach, more appropriate to the different types of services, linked to three broad tiers of commissioned services:

Next steps direction of travel

- Tier 1: Nationally commissioned services - Rare diseases, as well as a small number that need to be planned nationally

- Tier 2: Co-commissioned services – These are services not routinely delivered in every CCG or in every local hospital, but which are delivered in many localities across England and need to be sensitive to that defined geography, which may cover three or four CCGs in some cases, or thirty or forty in others. The proposal is that these services will be co-commissioned alongside CCGs from April 2015.

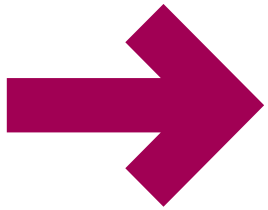
- Tier 3: Devolved services – Over time fully devolve some services to CCGs or groups of CCGs. These are services provided in most localities.

5 year ambitions on quality

“The definition of quality in health care, enshrined in law, includes three key aspects: patient safety, clinical effectiveness and patient experience……

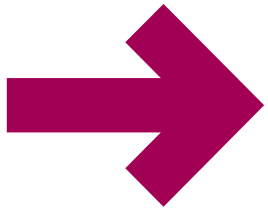
As national bodies we can do more by measuring what matters, requiring comprehensive transparency of performance data and ensuring this data increasingly informs payment mechanisms and commissioning decisions”.

AMBITIONS FOR QUALITY DEPEND ON DATA



Data, data, data

- Specifying evidence-based standards that we expect
- Measuring whether services meet the standard
- Knowing where patients are in the pathway/system and what is happening to them
- Knowing what trials are out there and how to get patients into them
- Measuring the experiences patients have and the outcomes they achieve
- Measuring helpful process or system proxies
- Publishing data – and learning – for information and continuous improvement
- Commercial data too – costs, staffing, prices etc
- Data at the heart and at the start: fit for purpose, accurate, complete, timely, responsive etc

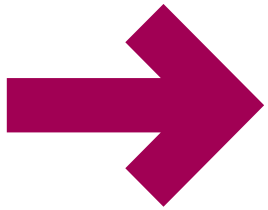


Children's cancer dashboard

- Median survival at 5 years for children with Leukaemia
- Median survival at 5 years for children with CNS tumours
- Median survival at 5 years for children with non CNS solid tumours
- Proportion of non-cancer deaths in cohort on treatment
- Proportion children requiring emergency admission who cannot be accommodated in the unit, either outliers within Trust or to another site

Children's Cancer dashboard continued

- Proportion children requiring emergency admission who cannot be accommodated in the unit, either outliers within Trust or to another site
- Occupancy rates on base ward
- Percentage of shifts where the ratio of nurses to beds for paediatric oncology inpatient beds meet peer review guidelines
- Number of chemotherapy SUIs
- Proportion of eligible children offered access to nationally available clinical trials
- Overall percentage compliance with IOG Measures
- Proportion of workforce that have qualifications/training in children's cancer



TYA Quality Standards

Domain 1: Preventing people dying prematurely

- Overall survival at 1 and 5 years
- Proportion of TYA patients discussed in the TYA MDT within 28 days of diagnosis

Domain 2: Enhancing the quality of life of people with long-term conditions

- Proportion of patients discussed within the TYA MDT who have a holistic assessment completed and documented
- Proportion of patients who have a treatment summary and care plan documented within 3 months of completion of treatment

TYA Quality Standards

Domain 3: Helping people to recover from episodes of ill-health or following injury

- Proportion of patients recruited to an NCRI clinical trial, where one exists

Domain 4: Ensuring that people have a positive experience of care

- % of patients who report receiving enough information in patient experience exercises

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

- % of patients dying within 30 days of start of last chemotherapy cycle

Any questions?

Thank you

Claire Foreman, Programme of Care Lead, Cancer & Blood (London Region)

claireforeman@nhs.net

Anthony Prudhoe, Programme of Care Lead, Women & Children (North Region)

a.prudhoe@nhs.net