Service Specification Number	**06/CEOL/0001**
Service/ care pathway	**Cancer services**
Commissioner Lead	**CCP for Cancer and End of Life**
Provider Lead	**DCHFT**
Period	**1 April 2012 – 31 March 2014**
Date of Review	

Key Service Outcomes

Domain 1 Preventing people dying prematurely

Domain 2 Enhancing quality of life for people with long term conditions

1. Purpose

1.1 Aims and objectives

This service specification aims to ensure that patients with a diagnosis of cancer:

- receive a high quality of care using evidence based treatments
- have a positive experience of care
- are treated in a timely way throughout their pathway of care
- receive treatment in the most appropriate place for that element of care
- are supported in progressing onto survivorship following successful treatment
- are supported in progressing onto palliative and end of life care where curative treatment proves not to be possible.

1.2 National/ local context and evidence base

More than one in three people will develop cancer during their lifetime, and it causes 28% of all deaths. Three quarters of cases diagnosed are in people aged 60 or over, and more than a third are in people aged 75 or over. As the demographics of Dorset include an elderly population significantly larger than the national average, the burden of cancer is equally greater than most other areas of the England.

In 2007 The Department of Health published its five year **Cancer Reform Strategy** which set out the challenges for cancer services and actions needed to address those challenges. The National Audit Office published an report examining how effectively elements of the Strategy were being delivered in November 2010. In January 2011 the Department of Health published an update on the CRS – **"Improving Outcomes: A Strategy for Cancer**". NICE has published a series of evidence based cancer **Improving Outcomes Guidance** documents which identify how specific cancers should be diagnosed and treated. These are used as the basis for the Measures used in the Peer Review process. NICE is also developing a library of Quality Standards to assist in commissioning and provision of services.

All of the above elements have been taken into account in developing this services specification.

2. Service Scope

2.1 Service Description

There are many cancer types and cancer is treated in a wide range of specialties. This specification is therefore high level, setting out the common elements that should be delivered across all areas of cancer referral, diagnosis, treatment and after-care. The aim is to ensure a consistent quality of care across all cancer pathways for patients, from primary care, through secondary care, and when needed, into tertiary care.

2.2 Any exclusion criteria

This specification does not cover screening for cancer but concentrates on the treatment pathway once cancer is suspected or diagnosed.

2.3 Geographic coverage/ boundaries

The area covered will vary according to the specific cancer type as where there is specialisation a wider area may be covered, however geographic coverage/boundaries and population covered must be clearly indicated in the Multi-Disciplinary Teams or Network Site Specific Groups Policy, Guidelines and Constitution.

2.4 Whole System Relationships

Each Provider is part of a Cancer Network. Providers within Dorset are part of the Dorset Cancer Network and are expected to take an active and supportive part in the Network. Each MDT team within each provider is expected to contribute to the appropriate NSSG. Where pathways link to providers outside the Dorset Cancer Network it is expected that the patient pathway is clearly defined, that responsibilities of each provider are clear within the pathway, and that the patient pathway within an individual provider meets a timescale that enables the other provider/s to meet the necessary waiting time targets.

2.5 Interdependencies with other services

Cancer services exist within specialities as well as being specialties in themselves. As such they are affected by the wider activity within that specialty. In addition diagnostic services such as radiology and pathology impact on the ability of cancer services to move a patient through their pathway to ensure commencement of treatment at the latest 62 days after the initial referral. It is therefore expected that the Provider ensures that diagnostic services are able to support cancer pathways that enable the 62 day target to be achieved.

2.6 Relevant networks and screening programmes

Cancer Services are expected to take an active part in the Cancer Network for their area. For Providers within Dorset this is Dorset Cancer Network.
Screening programmes are not included in this specification.

2.7 Training/ education/ research activities

It is expected that staff working with and supporting patients diagnosed with cancer will have received appropriate training and will receive update training as necessary. Training needs should be identified through staff PDR's and PDP's which will take place annually as a minimum.
Staff identified as requiring Advanced Communication Skills training should be supported to attend a suitable accredited course.
Staff who deal with patients moving into the palliative phase of their illness should have at least basic understanding of Gold Standards Framework and Liverpool Care Pathway.
Research activities will be undertaken as part of the National Institute for Health Research Cancer Research Network and Dorset Cancer Network and will be agreed through the relevant NSSG. All should meet appropriate research governance arrangements as per provider Trust policy.
MDT teams will ensure submission of relevant data to the four current nationally designated clinical audits:

- The National Lung Cancer Audit (LUCADA)
- The National Bowel Cancer audit (NBOCAP)
- The National Head and Neck Cancer Audit (DAHNO)
- The Oesophagogastric audit.

Providers will also take part in new national audits as they are introduced.

3. Service Delivery

3.1 Service model

The service model will comply with best practice as identified by NICE Improving Outcomes Guidance and Measures for each site specific area. All cancer service MDTs will link to the overarching NSSG for that service area. All will have agreed guidelines, operational policies and constitutions. All will partake in peer review as per agreed annual timetable. Clinicians undertaking surgery/treatment of patients will be expected to be part of the relevant MDT for their treatment area. Clinicians that are not part of the relevant MDT will not undertake treatments as compliance with the agreed pathway, and appropriate clinical oversight cannot be guaranteed. The provider is expected to ensure a level of attendance of pathologists at MDTs that meets cancer measures.

Chemotherapy

Providers will work with commissioners in achieving implementation of the National Chemotherapy Advisory Group report. Chemotherapy will be prescribed according to agreed formularies, regimens and algorithms which will be evidence based and agreed by the Network Chemotherapy and Drugs Group and the Prescribing and Medicines Management Group. Non-regimen prescribing will require approval according to the agreed process for prior approval or individual treatment requests. Access to the **Cancer Drugs Fund** will be via the approved Network and SHA processes. Full completion of the required forms will be necessary for these applications to be considered by the relevant groups.

Radiotherapy (Poole Hospital only)

The Provider will be expected to comply with "Towards Safer Radiotherapy (2008)" recommendations (BIR/IPEM/NPSA/SCoR/RCR). This document provides guidance for radiotherapy staff and risk managers in trusts where radiotherapy is delivered on the use of the classification and coding system described in Towards Safer Radiotherapy at local level; and the procedures for submitting the classified and coded data to the NPSA for analysis by the Health Protection Agency.

The Provider will also be expected to utilise the guidance included in "On Target: ensuring geometric accuracy in radiotherapy (2008)" (CoR/IPEM/RCR). This document describes and recommends the best evidence-based practices for geometric treatment verification. It also provides guidelines as to how individual centres may implement verification processes locally. Recommendations include for example that geometric verification is mandatory for all megavoltage x-ray external beam radiotherapy.

The Provider will work with commissioners in achieving implementation of the National Radiotherapy Advisory Group report.

The Provider will be expected to be aware of all relevant NICE Guidance as applied to the use of radiotherapy and to ensure its application as appropriate.

Staging data

In line with the Operating Framework for 2011/12 the provider is expected to include staging data in the information they feed to cancer registries. MDTs will therefore be expected to produce staging data on 70% of their cases. Activity without a record of staging will not be paid.

1:1 Support

"Improving Outcomes – A Strategy for Cancer highlights the growing evidence that co-ordinated care, such as that provided by CNSs, can deliver better outcomes for patients. Macmillan Cancer Support will be supporting the NHS to create additional 1:1 support posts during 2011-18. Providers will work with the Dorset Cancer Network and Macmillan to ensure a co-ordinated plan for rollout of this investment within Dorset to maximise the benefit for cancer patients within Dorset.

All patients will have access to assessment and care planning (holistic needs assessment).

Direct Access Diagnostics

" Improving Outcomes – A Strategy for Cancer aims to ensure that processes are in place to enable GPs to access directly:

- Chest x-ray to support the diagnosis of lung cancer
- Non-obstetric ultrasound to support the diagnosis of ovarian and other abdomino-pelvic cancers
- Flexible sigmoidoscopy/colonoscopy to support the diagnosis of bowel cancer
- MRI to support the diagnosis of brain cancer.

These aims are reflected in the 2011/12 NHS Operating Framework. While direct access CXR is already in place, direct access to the other three tests is not. It is anticipated that the Provider will work with commissioners for the remaining three tests to identify how this can be achieved without compromising GP access times now that the National Cancer Diagnostics Advisory Board criteria and timescales has been published.

Enhanced Recovery

It is expected that patients who are suitable will have access to an enhanced recovery programme for colorectal, urology and gynaecological surgery as this has been shown to improve outcomes.

Follow-up OPA's

See Section 3.6 regarding follow-up OPA's. Where follow-up appointments take place diagnosis should be specified on patient records to enable commissioners to identify cancer related follow-up activity. It is expected that the provider will work with the commissioner and with primary care during 2011/12 to develop and implement primary care based urology, colorectal and breast cancer services, to include care of patients with prostate, colorectal and breast cancer that are on a watch and wait pathway.

Equality

The provider is expected to ensure that they are aware of the distinct needs of different groups using their services, and that they address these needs to ensure equity of access and treatment for all.

Patient Information

"Improving Outcomes – A Strategy for Cancer" highlights the need for good patient information. Providers are expected in particular, to enhance the information available to patients on the benefits and toxicities of treatment. Commissioners will expect to see evidence of this action from the Provider in 2012/13. In addition, in the light of the patient experience survey in 2010, the Provider will be expected to ensure that the patient receives written information on their diagnosis and treatment and that information on finances is available for those patients/families that require it.

Oncology access

For oncology measures there will be a minimum requirement of oncologists" and specialist nurses" time specified for providing rapid acute oncology triage, and consultant assessment within 24 hours. In order to meet oncology access requirements a 24 hour helpline should be available for patients. For those patients admitted with neutropenic sepsis a one hour door to needle (antibiotic delivery) time should be achieved.

Providers will need to ensure that for patients having third and further line regimens of chemotherapy there is a wider MDT discussion to involve palliative care, the patient's GP and the patient themselves.

Cancer of the Unknown Primary

Providers will be expected to link to or host an MDT for cancer of the unknown primary and provide outcomes data including staging to the appropriate registries.

3.2 Care pathways

Care pathways will be developed and agreed by MDTs and NSSGs and will be reviewed annually and updated as needed to ensure continued compliance with best practice. These will be shared with commissioners. For some cancers where specialist treatment is needed the pathway may take patients to providers outside the Dorset area.

3.4 Location(s) of service delivery

Location of service delivery will be as per agreed pathway/operational policy as agreed by MDT/NSSGs. These should be reviewed annually and feedback from patients, including the cancer survey, should be considered in reviewing whether the location of delivery remains the most appropriate to meet patients needs. Equally, as treatments change and progress, the pathway should be reviewed to consider whether a treatment can be given safely at a location closer to patients' homes.

3.3 Days/ hours of operation

These will vary according to the specific cancer service but should be reviewed at least annually to ensure that they meet the needs of the patient group that they are treating. The exception to this is oncology support. Oncology measures require that there should be 24 hour access to oncology expertise for cancer patients admitted via Accident and Emergency overnight. In addition there should be a 24 hour advice line for patients receiving cancer treatments such as chemotherapy.

3.4 Referral Criteria and sources

Referral criteria and sources will be specified within the relevant service specific MDTs operational policy.

3.5 Referral processes

Referral processes will be specified within the relevant service specific MDTs operational policy. Referral processes will need to support compliance with national waiting time targets and onward referral to a tertiary provider will support compliance with the 62 referral to treatment target.

Referral to palliative care services will take place in a timely manner to maximise the opportunity for good symptom control and patient/family consideration of care and treatment options available to them.

Where a second opinion is sought all relevant information including imaging and histopathology slides will be dispatched within 5 working days to the centre where the second opinion is sought.

3.6 Discharge processes

Discharge processes will take place according to the relevant section requirement in the overall contract.

The provider will ensure that patients are discharged from their care at the appropriate point in the pathway. Follow-up outpatient appointments should take place only where there is an evidence base to support their benefit. Otherwise follow-up care should support survivorship as per Section 5.15-5.23 of “Improving Outcomes: A Strategy for Cancer” (2011). If not already in use the Provider should consider the use of PROMs (Patient Reported Outcome Measures) in identifying the follow-up services needed by cancer survivors following their treatment.

Providers will be expected to ensure the treatment summary record is completed and sent to the GP.

3.7 Response times and prioritisation

The national cancer waiting time standards will be met by the Provider.

Delivery of antibiotics should occur within one hour (door to needle time) for patients presenting with neutropenic sepsis.

4. Other

Length of Stay

The Provider will be expected to work with the Dorset Cancer Network team and Commissioners in supporting a reduction in outpatient appointments and reduced length of inpatient stay for cancer patients where there is a good evidence base to support this development. For Length of Stay providers are expected to achieve or make progress towards achieving the performance of the best performing quartile of Trusts. Implementation of Enhanced Recovery schemes in colorectal, breast, urology and gynaecology will assist with this development. An audit of the effect of Enhanced Recovery in colorectal and urology during 2011/12 will assist in identifying the benefit of this scheme.

Providers are expected to achieve or make progress towards achievement of the best performing quartile of Trusts in number of admissions per new cancer diagnosis. This will achieve a reduction in emergency admissions for cancer patients.

Chemotherapy Dataset

There will be the national introduction of the chemotherapy dataset in April 2012. The Provider will be expected to improve the collection and publication of data on chemotherapy activity, outcomes and costs during 2011/12 in order to be ready to fully implement

submission of the dataset from 1 April 2012.

Electronic Prescribing Systems

Providers will be expected to implement and use an electronic prescribing system and contribute to audit and other national databases.

Quality Standards

NICE is in progress of developing a comprehensive suite of Quality Standards. As these are developed for cancer services the Provider will be expected to ensure that they are able to meet these standards. Where standards are not currently met the Provider will work with the Commissioner to develop an action plan that enables Standards to be met within a reasonable timeframe.

Information Prescriptions

The National Cancer Action Team, Macmillan Cancer Support and Cancer research UK are working to support and develop Information Prescriptions for patients throughout the cancer pathway. It is expected that the Provider will support and adopt this development as it progresses.

5. Quality Requirements

Performance Indicator	*Indicator*	*Threshold*	*Method of Measurement*	*Consequence of breach*
National Cancer waiting time targets		As per national target thresholds	Monthly data submissions	
Delivery of antibiotics should occur within one hour (door to needle time) for patients presenting with neutropenic sepsis.		100% by September 2011	Quarterly data submissions	
Cancer pathways compliant with relevant NICE IOG	Peer Review	Compliance achieved, or action plan agreed and being implemented	Peer review	If the Provider is assessed at less than 50%for any service and investigation by DCN confirms this assessment, then the Trust will be given notice that without remedial action the service will be decommissioned
Staging Data recorded in 70% cases		As per national target thresholds	Quarterly data submissions	Non payment for activity where less than 50% staging data has been recorded

If required, relevant Quality Requirements from Schedule 3 Part 4 can be inserted here

6. Activity

6.1 Indicative Activity Plan

6.2 Capacity Review

If required, relevant parts of the Activity Plan and Capacity Review should be inserted here

7. Prices & Costs

7.1 Price

If required, relevant Prices from Schedule 2 Part 4 may be inserted below

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value (for this service)
National Tariff plus Market Forces Factor				
Non-Tariff Price (cost per case/cost and volume/block/other)*				
Total		**£**		**£**

**delete as appropriate*

7.2 Cost of Service by commissioner

Total Cost of Service	Co-ordinating PCT Total	Associate PCT Total	Associate PCT Total	Associate PCT Total	Total Annual Expected Cost
£	**£**	**£**	**£**	**£**	**£**