Transforming Cancer Services Team

Business Case: Cancer Care Review: a 4 Point Model for London

August 2017

Contents

Action requested:

This paper is provided for approval at the [ENTER NAME OF GROUP/BOARD]

On [ENTER DATE]

1 Executive Summary

The Transforming Cancer Service Team for London (TCST) developed a model for cancer as a long term condition[1] which was endorsed by the London Cancer Clinical Leads Advisory Group, London Cancer Commissioning Board and the Londonwide Local Medical Committee in 2015. The TCST is part of the Healthy London Partnership and this work stream has been designed with NHS England's (London) Primary Care Transformation strategy[2] in mind. In February 2015, a Task & Finish (T&F) Group was established with a membership of patients, primary and secondary health care professionals from the pan London Living with and Beyond Cancer Board to take cancer as a long term condition work stream forward. The work stream was project managed by the TCST.

The case for change in managing cancer as a long term condition can be summarised as follows:

- 1 in 2 people born after 1960 will get cancer sometime in their lifetime[3]
- There were 223,500 people living with and beyond cancer in London in 2013[4]
- Whilst more people are living longer following a diagnosis, they are not necessarily living in good health[5]
- 70% of people with cancer are estimated to have at least one other long term condition[6].
- 15 months after a cancer diagnosis, cancer patients are more likely to use emergency care and be admitted into hospital than other patients[7]
- The 2015 National Cancer Experience Survey showed that London based CCGs fall considerably short of the best in England (and lag behind England's average) on questions relating to the support patients received from their GP[8]

Patients with a recent diagnosis of cancer present in primary and secondary care with increased physical and psychological needs. We also know that people experience effects of treatment years after receiving it. It is for these reasons that for a large proportion of people who get cancer, it will become a long term condition that needs managing[9].

The Nuffield Trust has produced evidence showing 15 months after diagnosis these patients have 60% more A&E attendances, 97% more emergency admissions and 50% more contact with their GPs than a comparable group[10]. Macmillan have also produced evidence to show that 70% of people with cancer have at least one other long term condition[11]. The evidence show high blood pressure (hypertension) affects 42% of people with cancer, followed by 31% having cancer and obesity; 21% having cancer and a serious mental health problem; 19% having cancer and chronic heart disease and 17% having cancer and chronic kidney disease.

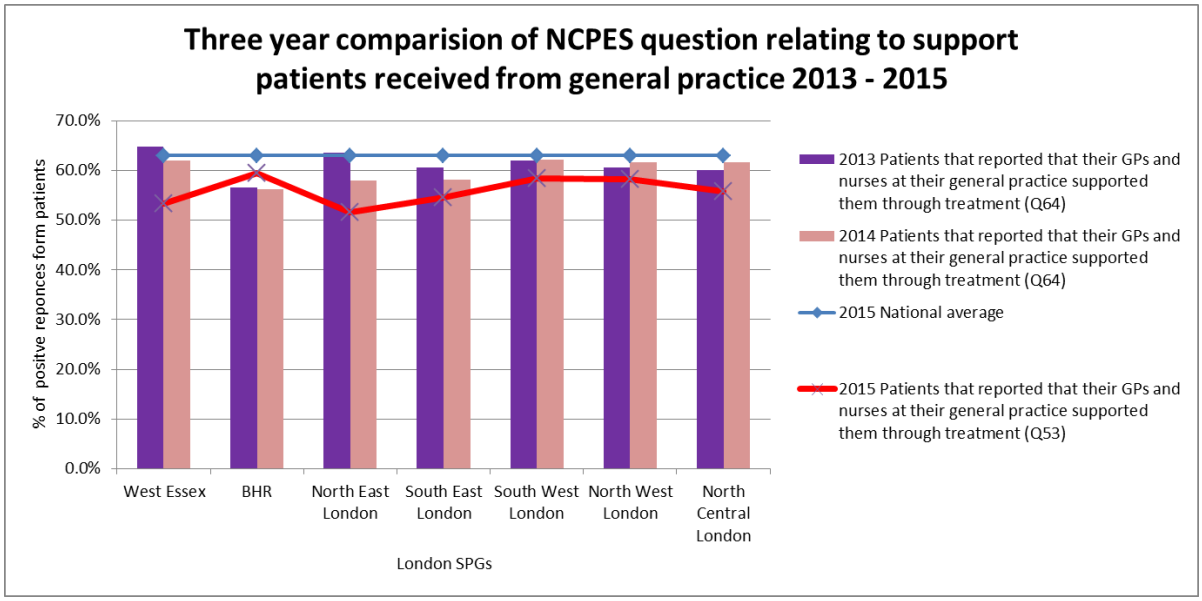
[1] https://www.myhealth.london.nhs.uk/system/files/Cancer%20Care%20Review.pdf
[2] https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2015/03/lndn-prim-care-doc.pdf
[3] http://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/lifetime-risk
[4] Macmillan NCSI Toolkit
[5] http://www.macmillan.org.uk/aboutus/news/latest_news/more-than-170,000-people-are-alive-despite-being-diagnosed-with-cancer-more-than-25-years-ago-.aspx
[6] http://www.macmillan.org.uk/documents/press/cancerandotherlong-termconditions.pdf
[7] http://www.nuffieldtrust.org.uk/sites/files/nuffield/140602_social_care_for_cancer_survivors_full_report.pdf
[8] http://www.ncpes.co.uk/index.php/reports
[9] http://www.macmillan.org.uk/throwinglightontheconsequencesofcanceranditstreatmentofcanceranditstreatment.pdf
[10] http://www.nuffieldtrust.org.uk/sites/files/nuffield/140602_social_care_for_cancer_survivors_full_report.pd f
[11] Macmillan Cancer Support: Cancer as a Long Term Condition
http://www.macmillan.org.uk/documents/press/cancerandotherlong-termconditions.pdf

The management of the unmet needs of cancer patients during and post-acute treatment has been captured by the National Cancer Survivorship Initiative in its Recovery Package[12]. This comprises holistic needs assessments (HNA), health and wellbeing events (HWBE), treatment summaries (TS) and finally the Cancer Care Review (CCR) in primary care that is generally governed by the Quality Outcomes Framework (QOF) in the form of an unspecified review to be completed within six months of diagnosis.

The 2015 Cancer Patient Experience Survey showed some of the lowest scored questions were related to support to patients with cancer and their families after discharge, provision of information about financial support, side effects of treatment, coordinated care between hospital and community services and the opportunity for patients to discuss fears and worries. London based CCGs fall considerably short of the best in England and lag behind England's average.

Table 1 below collated CCG level data for the question regarding support patients received from general practice from the 2013, 2014 and 2015 surveys. The data has been translated into SPG level data. CCG level data can be found in Appendix A

Table 1



Data source: http://www.ncpes.co.uk/

There is clear evidence that patients and carers would welcome a structured cancer care review and feel it legitimises raising their concerns about their cancer and the consequences of any treatment[13]. Numerous research papers show that people with cancer see an important role for primary care with regards to their diagnosis and treatment. This is particularly relevant at the point of end of initial treatment, often labelled the 'black hole syndrome', as frequent contact with secondary care reduces[14]

[12] http://www.ncsi.org.uk/what-we-are-doing/the-recovery-package

[13] Kendall, Marilyn et al. "Proactive Cancer Care in Primary Care: A Mixed-Methods Study." *Family Practice* 30.3 (2013): 302–312. *PMC*. Web. 4 Nov. 2015

[14] Carolyn Preston, Francine Cheater, Richard Baker, Hilary Hearnshaw "Left in limbo: patients' views on care across the primary/secondary interface" Quality in Health Care 1999;8:16–21

Finally, the Independent Cancer Taskforce Strategy[15] makes a number of recommendations for NHS England to work with CCGs regarding primary and community based care, two of which include:

- To embed approaches to reducing and managing long term consequences of treatment. (Rec 63).
- CCGs and Health and Wellbeing Boards to identify and promote best practice in approaches to support people living with and beyond cancer – secondary prevention agenda. (Rec 73).

There have been a number of projects across the UK where further guidance for the CCR has been proposed and in some cases incentivised. A report by the TCST[16] reviewed and compared these projects and the best practice from all taken forward into the creation of the following proposed 4 Point model.

1.1 4 point model

The aim of the 4 point model is to support people with a diagnosis of cancer to self-manage whilst they have cancer and in the longer term. For some people, they may live with terminal cancer (or they may be in remission) for many years or decades.

Cancer Care Reviews are one part of the model and they should be co-produced between the primary care clinician (GP, practice nurse or allied health professional) and the patient. The model includes a holistic CCR at the end of primary treatment which will compliment CCRs conducted as part of QOF. Both CCRs should be holistic, covering psycho-social needs, physical needs, needs of carers and support patients towards self-management. For the longer term, cancer can be integrated within a long term conditions management approach at practice or network/federation level. The model encourages initiatives such as the year of care model or integrated care frameworks as outline in the Five Year Forward View[17] to include people affected by cancer, particularly for those with cancer and multi-morbidities or social factors and NICE Guidance (NG56) Multimorbidity: clinical assessment and management[18].

Example trigger points for the London holistic CCR model are:

- At notification from hospital confirming a new diagnosis (via 2ww, routine outpatient, screening, A&E, other primary care routes, previous diagnosis/recurrence).
- Newly registered patients with cancer diagnosis in last 5 years.
- On receipt of Treatment Summary and /or transfer of care / discharge to community or primary care teams.

[15] Achieving World-Class Cancer Outcomes: a Strategy for England 2015-2020 http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf
[16] Transforming Cancer Services Team for London: Cancer as a long term condition, a review of Cancer Care Reviews and a proposed model for London 2015: https://www.myhealth.london.nhs.uk/system/files/Cancer%20Care%20Review.pdf
[17] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[18] https://www.nice.org.uk/guidance/ng56

Point 1: Patient added to cancer register (QOF CAN001)

The purpose of a register in QOF is to define a cohort of patients with a particular condition or risk factor. In some cases, this register then informs other indicators in that disease area.

QOF registers must not be used as the sole input for the purposes of individual patient care and clinical audit i.e. call and recall of patients for check-ups, treatments etc. There are patients for whom a particular treatment or activity is clinically appropriate but they may not meet the criteria as defined by the QOF register and therefore would not be picked up by a search based solely on the QOF register. As such, although QOF registers can be used to supplement clinical audit, they should be supported by appropriate clinical judgement to define which patients should be reviewed, invited for consultation to ensure patients do not miss out on appropriate and sometimes critical care[19].

Point 2: 1st intervention: First contact after diagnosis (QOF CAN003)

- Telephone call and/or letter to patient regarding recent diagnosis with invitation for the patient to attend the practice for a chat regarding their diagnosis. This could be completed by GP or practice nurse within six months of diagnosis (i.e. QOF CCR).

- Template letter for primary care is sent to patients who have just received a cancer diagnosis (templates are available from the TCST). The letter is to be tailored with the GP name, oncologist name, name of their key worker (if known), treating hospital; the type of cancer diagnosed and includes an outline of the recovery package that they should be receiving along with the Macmillan Top Ten Tips[20].

- Information for patient on what to expect as part of a Recovery Package with a prompt to request a key worker and HNA from secondary care if not provided by the time of CCR consultation. Pan London HNA[21] to be included for patient and family/carer for reflection and reviewed at subsequent CCR. Signposting to local support groups should also be included.

Point 3: 2nd intervention: Holistic cancer care review at the end of primary treatment as standard (local incentive scheme, sample available form TCST)

- Appointment triggered by a date entered into the Cancer Register and/or receipt of Treatment Summary / transfer to primary care.
- Extended consultation conducted by GP or primary care nurse depending on complexity of patients' needs (e.g. double or triple appointments may be required).
- Use of a clinical template for holistic CCR that captures whether the patient had an HNA in secondary care and their information needs (template available from the TCST). Using Treatment Summaries or discharge letters, discuss consequence of treatment (including late effects) and further advice on physical activity, healthy lifestyles, signs and symptoms to be aware of regarding recurrence carer's needs.
- Healthcare professional to use available screening tools to conduct a psychological assessment[22].
- Collection of minimum data for audit
- Professionals to undertake appropriate training modules in living with and beyond cancer. A bespoke prospectus of training modules will be available from the TCST.
- Patient and professional experience survey

[19] http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/faqs-and-queries/qof-faqs
[20] http://www.macmillan.org.uk/_images/what-to-do-after-treatment-guide_tcm9-300403.pdf
[21] http://www.londoncancer.org/media/79850/London-Holistic-Needs-Assessment_print-version_v2.2_HW.pdf
[22] https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf

- Primary care MDT meeting to discuss patients on register outlining care planning actions and review any Significant Event Audits (SEAs) related to recurrence or subsequent primary cancer diagnosed via emergency routes. TCST Primary Care Checklist is available for local use[23].

Point 4: 3rd intervention: Cancer incorporated and reviewed at an annual LTC Review (QOF generic, long term conditions local incentive scheme, NICE Guidance for Multimorbidity (NG56))

- Annual review may be for a period of time, for example up to five years, or it may be indefinite. It may also only apply to groups patients who have specific needs e.g. multi-morbidities, social risk factors, part of a local integrated care framework. Figure 1 below outlines the proportion and number of people with cancer living with other long-term health conditions. Figure 2 outlines proportion by age.
- The LTC review should include a conversation regarding the person's psycho-social and physical needs re cancer (e.g. preventing recurrence and detecting and/or managing any consequences of treatment), healthy lifestyle advice, as well as any other long term conditions and/or social risk factors that the person may have. Needs of carers should also be taken into account.

Figure 1: proportion and number of people with cancer living with other long-term health conditions[24]

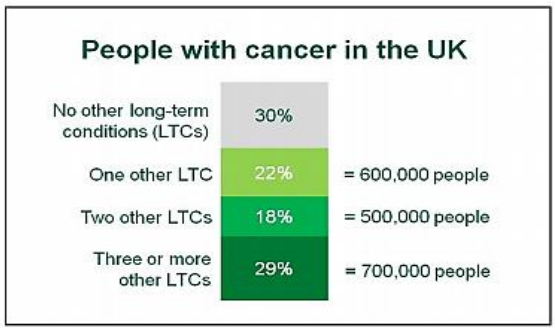
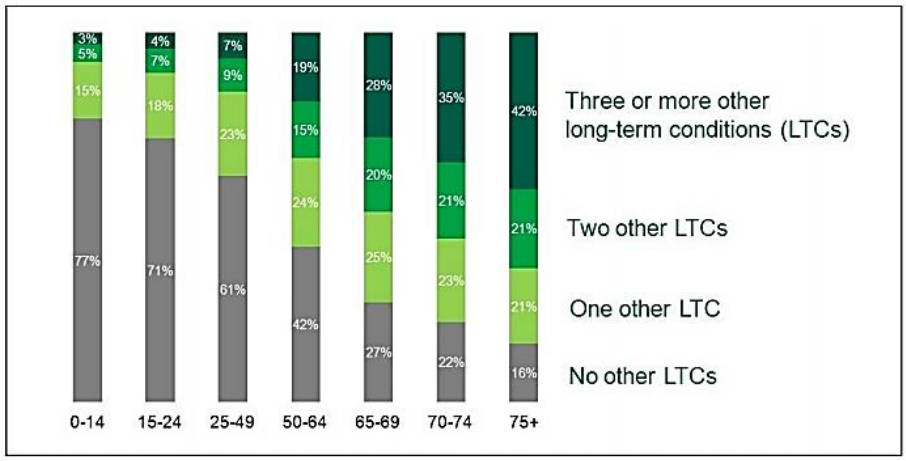


Figure 2: proportion of people with cancer living with one or more other long-term health conditions, by age group[25]



[23] https://www.healthylondon.org/sites/default/files/Primary%20Care%20Cancer%20Checklist%20-%20ED%20%26%20LWBC_final_0.pdf
[24] http://www.macmillan.org.uk/documents/press/cancerandotherlong-termconditions.pdf
[25] ibids

1.2 Options Appraisal

This paper outlines a proposal to introduce a proactive 4 Point model for cancer care reviews.

The model is broken down into five viable options which are considered within this proposal:

	Option	Description	Appraisal	Additional funding for cancer patients required?
1	Do nothing	Cancer care review regime continues for patients in the form of an unspecified review to be completed within 6 months of diagnosis. **Payment through QOF CAN001 and CAN003.**	This option requires no additional funding. However, there is no standardised approach to conducting CCRs. Therefore there would be no improvement to patient experience or ability to self-manage.	No
2	Standardised Cancer Registers and Cancer Care Reviews and CAN001 and CAN003 (QOF) only	STP/CCG-wide adaption of standardised CCR templates to conduct reviews. This involves patient added to cancer register and **t**elephone call and/or letter to patient regarding recent diagnosis with invitation for the patient to attend the practice for a cancer care review within six months of diagnosis. This could be completed by GP or practice nurse. **Payment through QOF CAN001 and CAN003**.	This option would be viable in areas where financial incentives are not available. Payments would be made through QOF and quality assured via primary care contracting where existing exceptions and exclusions would apply. This option would: • Ensure a standardised approach and reduce variation in the quality of CCRs • Ensures that the contact by primary care with the patient is initiated at the most appropriate point, for example once a diagnosis has been confirmed.	No
3	Implement holistic cancer care reviews at the end of primary treatment (usually occurs within	An extended consultation at the end of active treatment conducted by GP or nurse depending on complexity of patients' needs (e.g. double or triple appointments where appropriate). This extended appointment to be offered on receipt of a discharge letter and/or treatment summary from secondary care. Standardised use of clinical templates for holistic CCR such as the Macmillan or TCST templates	**This option:** • Commissions primary care to deliver high quality and holistic Cancer Care Reviews through a local incentive schemes • Supports the delivery of education and training in primary care of cancer as a Long Term Condition • Contributes to building the evidence based for managing Cancer as a Long Term Condition e.g.	Yes

	6 -15 months of diagnosis)	that captures the social, psychological and physical consequence of cancer and its treatment. The appointment should include advice on physical activity, signs and symptoms to be aware of regarding recurrence and assessing carer's needs. Required processes include: • Collection of minimum data for audit • Professionals to undertake training modules • Patient and professional experience survey • Primary care MDT meeting to discuss patients on register outlining care planning actions and review any Significant Event Audits (SEAs) **Payment through locally commissioned incentive scheme**	through local evaluations and other data • Promotes data collection and maintenance as part of the Cancer Register (CAN001) • Could be achieved as part of a Network / Federation model (under a Networked or Federated schemes) • Identifies high-risk and high-cost patients as most likely to suffer from consequences of treatment and are high users of unplanned care teams/services.	
4	Implement Option 2 plus Annual review	Annual review may be for a period of time, for example up to five years or indefinitely pending complexity of patient needs. **Payment through integrated care schemes (not cancer specific) as part of delivering NG56**	**Preferred option - where additional funding is not available.** In addition to benefits outlined in option 2, this option: • Defines cancer as a long term condition • Includes people affected by cancer within integrated care frameworks • Supports primary care in the long term management of patients living with and beyond cancer.	No
5	Option 3 plus annual review	An extended consultation at the end of active treatment using standardised clinical templates for holistic CCR followed by an annual review.	**Preferred option - where additional funding is available**. Benefits outlined in Options 2 and 4	Yes

1.3 Benefits of the 4 Point model is summarised below:

Group	Benefits
For patients	Knowledge that GP / practice is aware of the diagnosis and available to support them Subsequent access to specialist if needed, triaged by primary care after primary treatment ends. Particularly referrals related to consequences of treatment that could occur up to and over 15 months after discharge from hospital. Integration of personalized and person-centered care with other long term conditions and social factors Needs of carers are taken into account
For primary care	Improved service for patients measured through the National Cancer Patient Experience Survey More structured caseloads that are integrated with other long term conditions and services Providing holistic, integrated care led by primary care Opportunity for primary care nurses and non-specialist allied health professionals to be up-skilled to deliver holistic CCRs and manage cancer as a long term condition.
For acute providers	Encourages the delivery of the Recovery Package, namely completion of treatment summaries, where explicit consequences of treatment are clearly outlined. Supports reduction of emergency attendances, emergency admissions and length of stay (and associated improvements in a range of constitutional waiting time standards – A&E, RTT and cancer.
For commissioners	Improved quality of life for local population Improved communication between patient and primary care teams Fewer patients 'lost in the black hole syndrome'[26] after primary treatment finishes Consequences, such as lymphedema; bladder; bowel and sexual dysfunction; psychological and emotional problems; cancer related pain and fatigue can be treated very effectively (clinically and economically) if diagnosed early. Monitoring consequences of treatment could reduce emergency attendances, emergency admissions and length of stay. Increased rates in early detection of recurrence and new primary cancer.

[26] Carolyn Preston et al "Left in limbo: patients' views on care across the primary/secondary interface" *Quality in Health Care* 1999;8:16–21

The financial impact is as follows (please refer to Section 6 for more details):

[INSERT SUMMARY based on CCG/SPG calculations]

The outpatient impact is as follows:

[INSERT SUMMARY based on CCG/SPG calculations]

This proposal has the full support of:

[List the boards/groups that have approved this business case]

CCG Senior Management

Team CCG Cancer Locality Group

Acute Trust Cancer Board

CCG Governing Board

SPG Leads

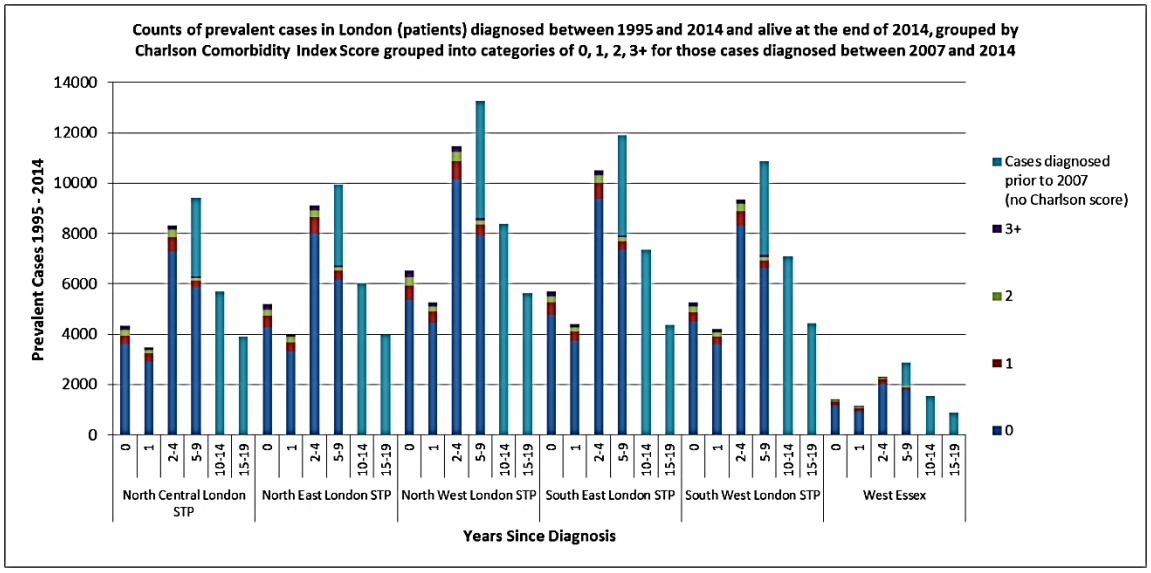
GP Federation

Local Medical Committee

2 Cancer prevalence in London and West Essex

The number of people living more than 5 years from initial diagnosis is predicted to more than double between 2010 and 2030. Currently 70%[27] of people who have a diagnosis of cancer have at least one other long term condition. This has led to a shift in thinking of cancer as an acute illness to a chronic one. Figure 3 below outlines the Charlson comorbidity index which predicts the one-year mortality for a patient who may have a range of comorbid conditions, such as heart disease, AIDS, or cancer. Each condition is assigned a score of 1, 2, 3, or 6, depending on the risk of dying associated with each one. Scores are summed to provide a total score to predict mortality.

Figure 3 Cancer prevalence in London and West Essex: *1995-2014 cohort*



Source: Data extracted from Cancer Analysis System (CAS), March 2017. Produced in partnership by Transforming Cancer Services Team (TCST) London and the National Cancer Analysis and Registration Service (NCRAS)

The National Cancer Survivorship Initiative[28] has highlighted the immediate and long term physical and psychological impact that cancer can have on those who have recovered. It

[27] http://www.ncsi.org.uk/what-we-are-doing/the-recovery-package
[28] ibids

states that many cancer survivors have unmet needs, particularly at the end of primary treatment whilst others are struggling with the consequences of treatment. The recommended 'Recovery package' model comprises four aspects: holistic needs assessments (HNA), health and wellbeing events (HWBE), Treatment Summaries (TS) and finally the cancer care review (CCR) in primary care.

3 Current Cancer Care Review processes (QOF)

The recovery package interventions have been included in London's acute commissioning intentions every year since 2012/13. Acute providers are expected to implement all interventions that relate to their services (HNA, TS, HWBE) in parallel to a cancer are review in primary care. HNAs and HWBEs may also take place in the community. Furthermore, the Five Year Forward View[29] and associated Sustainable Transformation Plans for London[30] support the move for out of hospital care for suitable patients.

Patients are typically offered a cancer care review within six months of diagnosis. Studies show two inter-related themes regarding patients' views of quality of consultation with GPs. These are the perceived competence of the doctor, and the doctors' empathic concern[31]. In addition, patients may define "quality" in general practice and primary care as being a holistic approach to care[32,33].

The national Cancer Care Review process is currently governed by the Quality and Outcomes Framework (QOF) and requires primary care to carry out a one-off cancer care review at a maximum of 6 months post cancer diagnosis. Practices can claim a maximum of 11 QOF points against two indicators for cancer outlined in Table1. The value of a QOF point for 16/17 is £165.18[34] . The payments are weighted by list size (the Contractor Population Index (CPI)) and in the clinical domain by disease prevalence.

Table1: QOF indicators for cancer

Cancer (CAN)	Indicator	2016/2017 points	2016/2017 achievement threshold
CAN001	The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'	5	-
CAN003	The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis	6	50-90%

[29] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[30] https://www.england.nhs.uk/stps/view-stps/#london
[31] S.W Mercer et al: "Quality in general practice consultations; a qualitative study of the views of patients living in an area of high socio-economic deprivation in Scotland", BMC Family Practice 2007
[32] S.W Mercer et al: Patient-centred Medicine: Transforming the Clinical Method. Thousand Oak (CA): Sage; 1995.
[33] F Borrell-Carrio, AL Suchman, RM Epstein: "The biopsychosocial model 25 years later: principals, practice, and scientific inquiry". Ann Fam Med 2004,
[34] http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/quality-and-outcomes-framework/changes-to-qof-2016-17

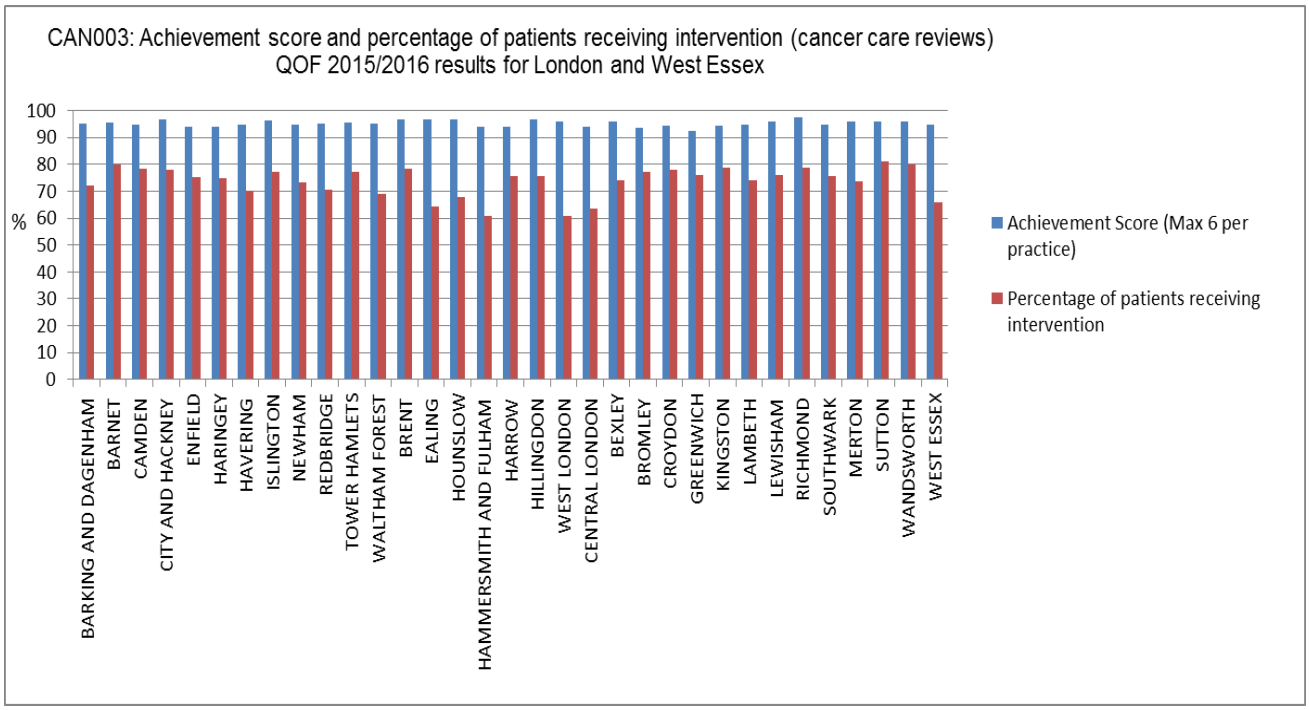
The findings of the two surveys of London-based primary care professionals show that not only is the quality of the current CCR provision under QOF variable, but so is the actual provision of the review itself. The graph in Figure 2 below shows the wide variation in completion of these reviews for patients across CCGs in London. This may be due to time and appointment constraints, but also due to the lack of clarity of the aims of the review and what it needs to cover[35].

With rapidly increasing workloads and many competing priorities, GPs would like to see a more structured pathway[36]. Patients would like primary care to offer a service that caters for their long term needs and reduce the sense of being alone with their cancer after primary treatment ends[37].

The long term future of QOF is unknown with many CCG across the UK (NHS Somerset, NHS Dudley, NHS Aylesbury Vale CCG and practices across Scotland) opting to develop local incentive schemes to replace QOF. Although QOF has provided strong financial incentives for general practices, these have not necessarily resulted in changes in clinical activity, improved health outcomes, or reduced health inequalities.[38]

2015/2016 QOF data for London. CAN003: the percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis.

Figure 2



[35] F Borrell-Carrio, AL Suchman, RM Epstein: "The biopsychosocial model 25 years later: principals, practice, and scientific inquiry". Ann Fam Med 2004,

[36] Transforming Cancer Services Team for London: Cancer as a long term condition, a review of Cancer Care Reviews and a proposed model for London 2015: https://www.myhealth.london.nhs.uk/system/files/Cancer%20Care%20Review.pdf

[37] ibid

[38] The King's Fund "Impact of Quality and Outcomes Framework on health inequalities" 2011 https://www.kingsfund.org.uk/sites/files/kf/Impact-Quality-Outcomes-Framework-health-inequalities-April-2011-Kings-Fund.pdf

4 Recommendation

Analysis of the options appraisal outlined in section 1.2 shows:

Option 4 would be viable in areas where financial incentives are not available. Payments would be made through QOF and quality assured via Read code/SNOMED[39] audits by the CCG. It would:

- Ensure a standardised approach and reduce variation in the quality of CCRs
- Ensure contact made by primary care with patient is initiated at the most appropriate point, for example once a diagnosis has been confirmed.

Option 5 full implementation of a holistic CCR at the end of active treatment and an annual review of patients where appropriate, would the preferred model, where funding for an incentive scheme is available. This is because it:

- Defines cancer as a long term condition within integrated care frameworks (as per NICE Guidance 56)
- Commissions primary care to deliver high quality and holistic Cancer Care Reviews at the time when patients have said they need them most (i.e. at the end of active treatment)
- Supports the delivery of education and training in primary care of cancer as a Long Term Condition
- Contributes to building the evidence based for managing Cancer as a Long Term Condition e.g. through local evaluations and other data
- Promotes data collection and maintenance as part of the Cancer Register (CAN001)
- Could be achieved as part of a Network / Federation model (under a Networked or Federated schemes)

5 Risks and issues

The following risks and issues have been considered

	Risk	1 = low, 5 = high			Mitigation
		Probability	Impact	Risk score	
1	Low engagement from partner CCGs	2	3	6	CCGs to agree local commissioning arrangements with GP federations/networks
2	Low engagement from practices	3	3	9	Service to be offered at level of GP federation so some practices can offer the service on behalf of all Consider local incentive schemes for practices

[39] https://www.digitalhealth.net/2015/10/snomed-to-replace-read-codes-by-2020/

3	Secondary care specialists not completing and/or transferring treatment summaries to primary care	2	5	10	Delivery of treatment summaries monitored through performance reporting and regular commissioner/provider discussions
4	Patient safety	2	5	10	Patient safety is significantly mitigated by effective safety netting systems (which can safety net for the risk of recurrence of cancer, subsequent primary cancers and late effects of treatment). This risk is also present in secondary care discharge led follow up
5	Under-skilled primary care workforce	3	4	12	Holistic cancer care reviews should be accompanied by an education and training plan so that primary care staff are prepared for this role

6 Cost analysis

In determining the financial impact of this proposal the following assumptions have been made:

Sector	**Description**	**Cost per patient***
QOF payment	The total value of CAN QOF points for 2016/17 was £165.18. Maximum 11 points for CAN001 and CAN003	£165.18[40]
Holistic CCR after active treatment	Appointment or 'new patient' appointment (10-15 mins) with primary care nurse	*£33.00
	Appointment or 'new patient' appointment (10-15 mins) with GP	*£45.00

*costs for primary care are shown for illustration purposes; these may change depending on local negotiations. Costs are based on advice from Surrey and Sussex LMC, the cost for the appointment excludes phlebotomy as a result of suspected reoccurrence which can be claimed under a phlebotomy LCS. If an annual review is clinically indicated, the cost would remain at £31.67.

**costs outlined above include any associated admin costs and outlined as costs per patient per year.

[40] http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/quality-and-outcomes-framework/changes-to-qof-2016-17

Please note that no costs have been allocated for:

- Project management to support early implementation of Options 2, 3 or 4
- Patient education/self-management events
- Primary care workforce (GP/practice nurse) learning and development events
- Rehabilitation and support service costs as these should be the same routine referrals
- CCG/STP development and maintenance of a directory of services

7 Tools and Resources

- Transforming Cancer Services Team for London: Cancer as a long term condition, a review of Cancer Care Reviews and a proposed model for London 2015: https://www.myhealth.london.nhs.uk/system/files/Cancer%20Care%20Review.pdf

- Primary Care Checklist: https://www.healthylondon.org/sites/default/files/Primary%20Care%20Cancer%20Checklist%20-%20ED%20%26%20LWBC_final_0.pdf

- Macmillan GP advisers have collaborated with members of the Macmillan primary care community to develop a '10 top tips' series of downloads. The PDFs below offer practical hints, tips and information on a variety of different primary care situations and scenarios.: http://www.macmillan.org.uk/about-us/health-professionals/resources/primary-care-top-ten-tips.html

- A guide for Cancer Leads and GPs outlining treatment summaries is available: https://www.healthylondon.org/sites/default/files/Treatment%20summary%20briefing%20for%20Cancer%20Leads%20Aug%202016.pdf

- London Treatment Summaries are available to view: http://www.londoncanceralliance.nhs.uk/information-for-healthcare-professionals/forms-and-guidelines/lca-patient-experience-programme/treatment-summaries/

- Sample holistic needs assessment (HNA) is available to view: http://www.londoncancer.org/media/79850/London-Holistic-Needs-Assessment_print-version_v2.2_HW.pdf

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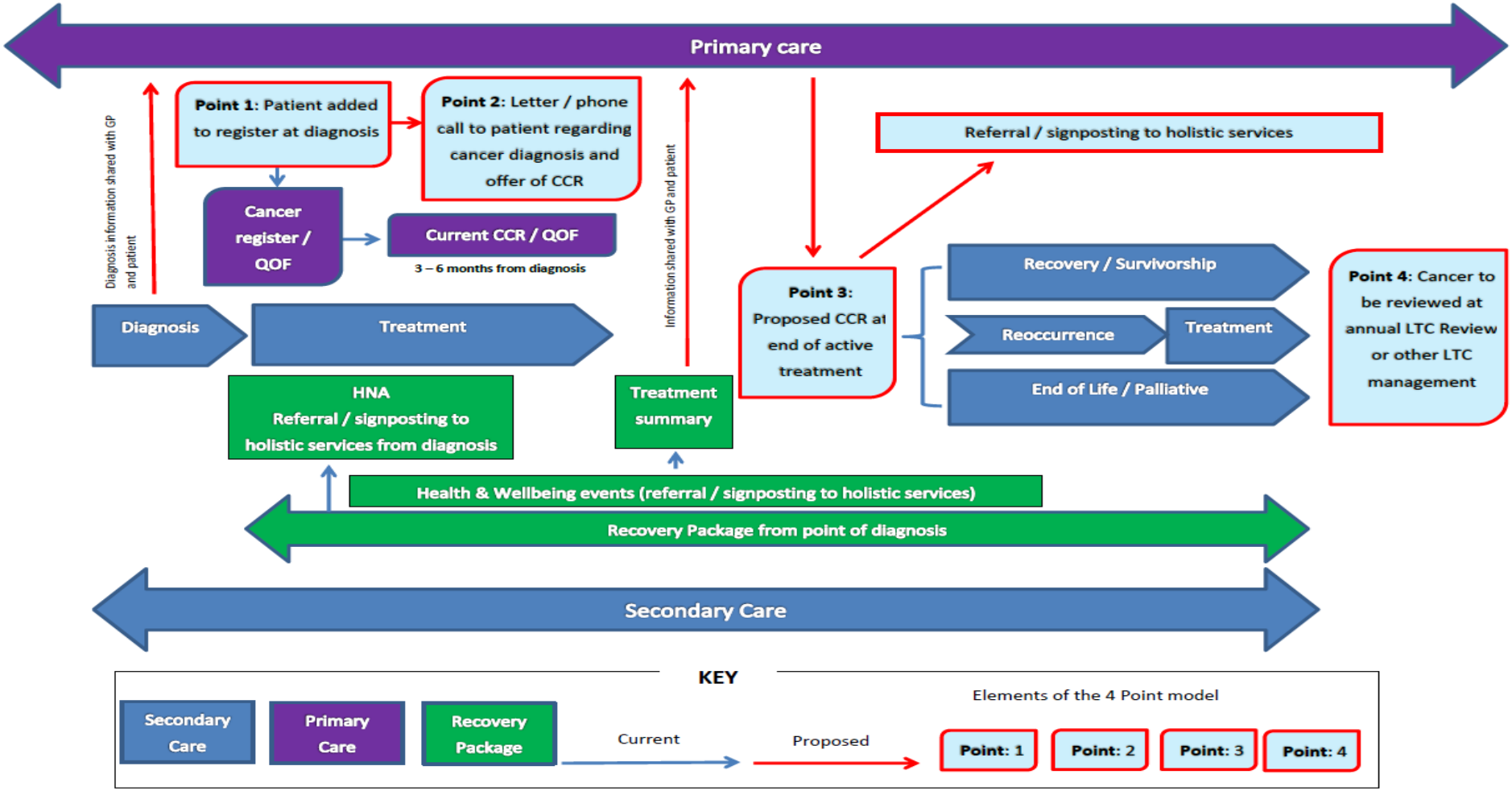
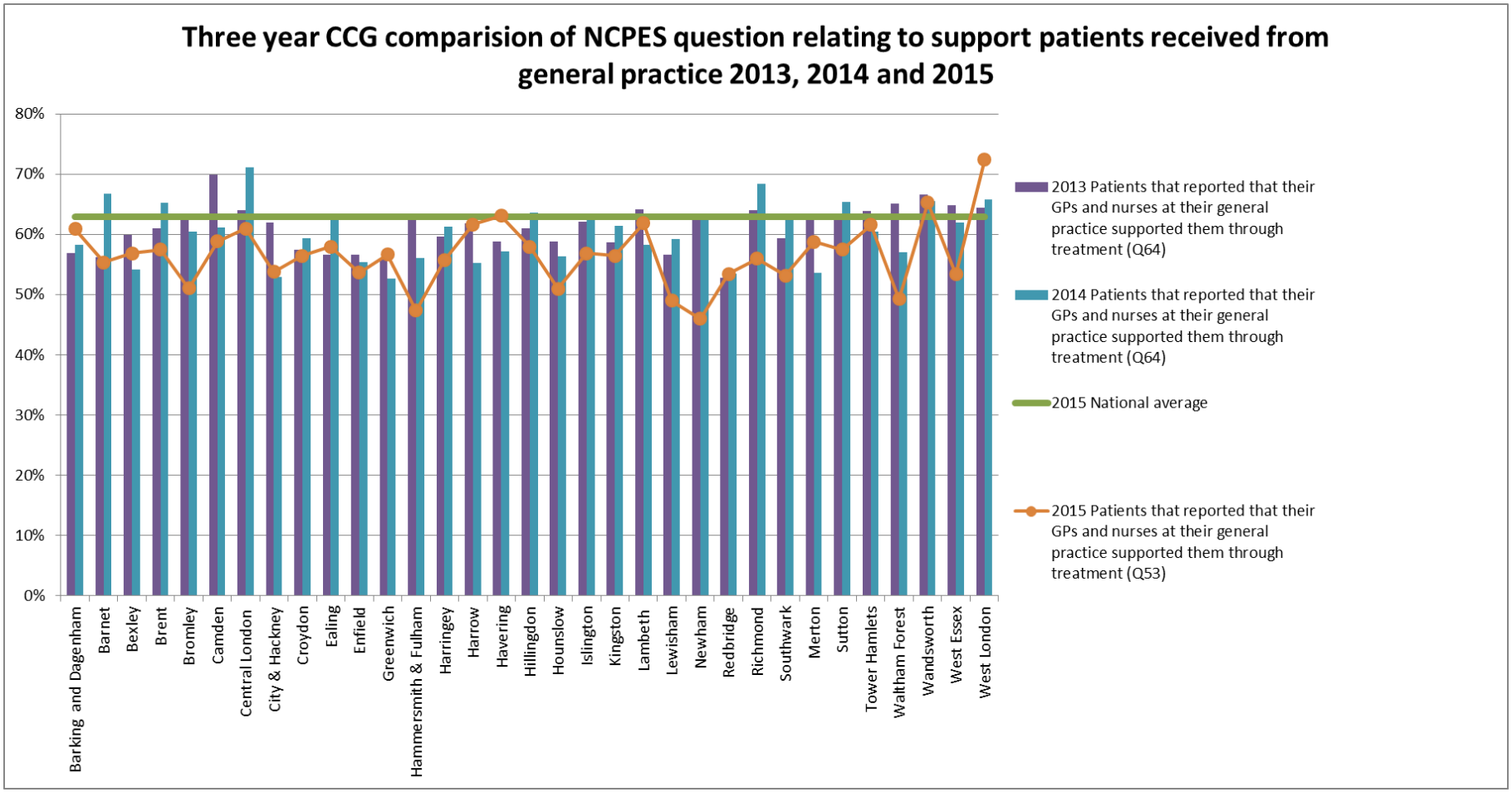
Appendix 1: 4 Point model for Cancer Care Review



Appendix 2: CCG level data for NCPES question regarding support patient received from general practice



Appendix 3a: Projected costs for implementing 4 Point model by CCG

Cost of a holistic CCR appointment (after active treatment) in Primary care at £45* per appointment

CCG	1-2 yrs prevalance (number of patients)	5-10 yrs prevalance (number of patients)	Total cost 1 -2 yr	Total cost 5-10 yrs
NHS Barking and Dagenham CCG	355	930	£15,975	£41,850
NHS Barnet CCG	894	2252	£40,230	£101,340
NHS Bexley CCG	676	1651	£30,420	£74,295
NHS Brent CCG	611	1686	£27,495	£75,870
NHS Bromley CCG	950	2277	£42,750	£102,465
NHS Camden CCG	468	1353	£21,060	£60,885
NHS Central London (Westminster) CCG	311	1208	£13,995	£54,360
NHS City and Hackney CCG	468	1248	£21,060	£56,160
NHS Croydon CCG	838	2524	£37,710	£113,580
NHS Ealing CCG	685	1759	£30,825	£79,155
NHS Enfield CCG	758	1783	£34,110	£80,235
NHS Greenwich CCG	558	1380	£25,110	£62,100
NHS Hammersmith and Fulham CCG	378	974	£17,010	£43,830
NHS Haringey CCG	499	1321	£22,455	£59,445
NHS Harrow CCG	559	1468	£25,155	£66,060
NHS Havering CCG	672	1924	£30,240	£86,580
NHS Hillingdon CCG	574	1452	£25,830	£65,340
NHS Hounslow CCG	505	1109	£22,725	£49,905
NHS Islington CCG	412	1076	£18,540	£48,420
NHS Kingston CCG	392	1191	£17,640	£53,595
NHS Lambeth CCG	648	1642	£29,160	£73,890
NHS Lewisham CCG	589	1486	£26,505	£66,870
NHS Merton CCG	439	1379	£19,755	£62,055
NHS Newham CCG	421	1020	£18,945	£45,900
NHS Redbridge CCG	586	1412	£26,370	£63,540
NHS Richmond CCG	535	1358	£24,075	£61,110
NHS Southwark CCG	554	1420	£24,930	£63,900
NHS Sutton CCG	554	1311	£24,930	£58,995
NHS Tower Hamlets CCG	303	834	£13,635	£37,530
NHS Waltham Forest CCG	533	1020	£23,985	£45,900
NHS Wandsworth CCG	585	1853	£26,325	£83,385
NHS West Essex	966	2286	£43,470	£102,870
NHS West London CCG	966	1598	£43,470	£71,910
Total	**19242**	**49185**	**£865,890**	**£2,213,325**

*£45 outlined for illustration purposes only.

Appendix 3b: Projected costs for implementing 4 Point model by STP

Cost of a holistic CCR appointment (after active treatment) in Primary care at £45* per appointment

CCG	1-2 yrs prevalance (number of patients)	5-10 yrs prevalance (number of patients)	Total cost 1 -2 yr	Total cost 5-10 yrs
NCL STP Islington, Camden, Haringey, Enfield, Barnet	3031	7785	£136,395	£350,325
NEL STP Waltham Forest, Tower Hamlets, Newham, City & Hackney	1725	4122	£77,625	£185,490
BHR STP Barking, Havering, Dagenham and Redbridge	1613	4266	£72,585	£191,970
SEL STP Greenwich, Lewisham, Lambeth, Southwark, Bromley, Bexley	3975	9856	£178,875	£443,520
SWL STP Croydon, Merton, Sutton, Richmond, Kingston, Wandsworth, Sutton	3343	9616	£150,435	£432,720
NWL STP Central London, West London, Brent, Harrow, Hillingdon, Hammersmith & Fulham, Hounslow, Ealing	4589	11254	£206,505	£506,430
West Essex (part of Essex STP)	966	1598	£43,470	£102, 870
Total	**19242**	**49185**	**£865,890**	**£2,213,325**

4 Point*£45