

How to
REDUCE EXCESS MORTALITY FROM CANCER IN
AREAS WITH THE WORST HEALTH AND HIGHEST
LEVELS OF DEPRIVATION

CONCLUSION OF THE COLLABORATIVE BETWEEN
THE HEALTH INEQUALITIES NATIONAL SUPPORT
TEAM AND THE NATIONAL CANCER ACTION TEAM

GUIDE FOR HEALTH AND WELLBEING BOARDS
& GP COMMISSIONING CONSORTIA

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1. Introduction

The purpose of this report is to advise those responsible for planning health and wellbeing services for people in areas of poor health what they can do to reduce the rate at which people die from cancer – helping those sections of population with most need improve fastest.

The primary audience is emerging Health and Wellbeing Boards ('Boards'), and Cancer Networks, working with GP Commissioning Groups.

Between 2007 and 2011, the Health Inequalities National Support Team (HINST), working with the National Cancer Action Team (NCAT), visited local Partnerships in more than 60 areas. This report draws on the work of the partnerships in reducing health inequalities in cancer and is the concluding chapter of the full report of HINST'S and NCAT's work in spearhead PCTs¹. That work and the production of this report have been led by Professor Chris Bentley from HINST and Kathy Elliott from NCAT.

This report provides an overview of practical approaches, with signposts to source information – using the format of the NHS Doncaster/NCAT 'how to' guide *Early Lung Cancer Intervention in Doncaster: Doncaster 3 Week Cough*².

The underlying premise is that a straightforward but systematic approach to reducing excess mortality from cancer can have a population level impact.

Peter Counsell³

January 2011

¹ *Tackling Inequalities In Cancer: The outcome of the collaboration between the Health Inequalities National Support Team and the National Cancer Action Team in supporting work to reduce deaths from Cancer in areas with worst health and greatest need* (2011) – available shortly via www.naedi.org/

² R Suckling, May 2010, *Early Lung Cancer Intervention in Doncaster: Doncaster 3 Week Cough: How To Guide*, NHS Yorkshire and the Humber, NCAT and NHS Doncaster
http://info.cancerresearchuk.org/prod_consump/groups/cr_common/@nre/@hea/documents/generalconten/cr_042781.pdf

³ Thanks to Ros Bayley for editing this report ros.bayley@fairadsl.co.uk

Step 1: Describe the Problem

(Population Health Needs)

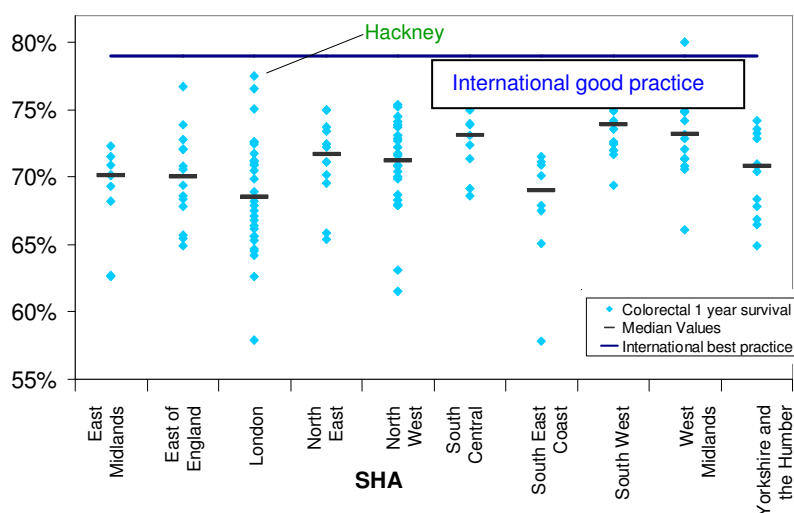
Defining a problem accurately is the first step to understanding how to address it.

Most of the annual reports of primary care trust (PCT) directors of public health contain some analysis of the incidence, prevalence and mortality rates of the most common cancers. Boards will want to know whether the local situation is unusual, how it compares with other (similar) PCT areas and whether it is getting better or worse. However, what they will also need to establish is how the situation can be improved, and for this purpose they will need more information related to survival rates.

Boards need the detail to be able understand which cancers are killing people disproportionately, and whether the local situation is different from that in similar areas. One-year survival rates are the key to this. Much of the difference in five-year survival for each cancer can be attributed to poor one-year survival in England⁴ compared to the rest of Europe, and benchmarking highlights the need for local action.

The second annual report on the Cancer Reform Strategy⁵ lists the one-year survival rates for breast, colorectal and lung cancers for every PCT in England. If there is an asterisk next to the figure the rate is in the best quarter for England – and there may be elements of good practice to learn from. If there is an exclamation mark the rate is in the worst quartile – and action is needed.

1 Year Survival in PCTs - Colorectal Cancer



The National Cancer Intelligence Network (NCIN) and NCAT have very helpfully produced charts⁶ that summarise this information in graphic form, and which enable each PCT's position to be plotted against every other in the country. Using the tables in the Cancer Reform Strategy second annual report, and the charts, it is possible to produce a chart like this for Hackney.

Another way of benchmarking is to look at the contribution cancer makes to local death rates. The health inequalities intervention tool⁷ enables you to see whether specific cancers have an unusually high impact on the death rates in the

⁴ Department of Health, 12th January 2011, *Improving Outcomes: A Strategy for Cancer*, Gateway reference 15108

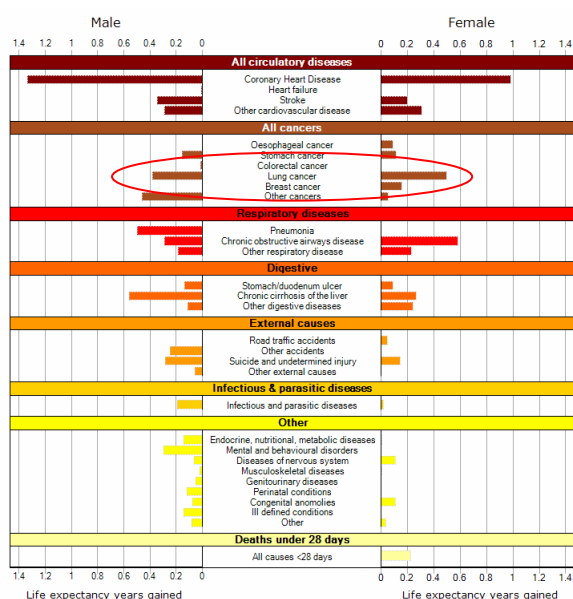
⁵ Department of Health, December 2010, *Cancer Reform Strategy: Achieving local implementation – second annual report*, Gateway reference 12927

⁶ Charts produced for SHA/ DH regional events on cancer awareness and early diagnosis 2010

⁷ Health Inequalities Intervention Tool for All Areas

http://www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesAllAreas2008.aspx

most deprived areas, that is whether they are contributing to excess mortality. Charts show the mortality of people in the most deprived fifth of local areas and demonstrate how much longer they would live if they had the same death rates for those conditions as people in the least deprived fifth of the district, or against the England average.



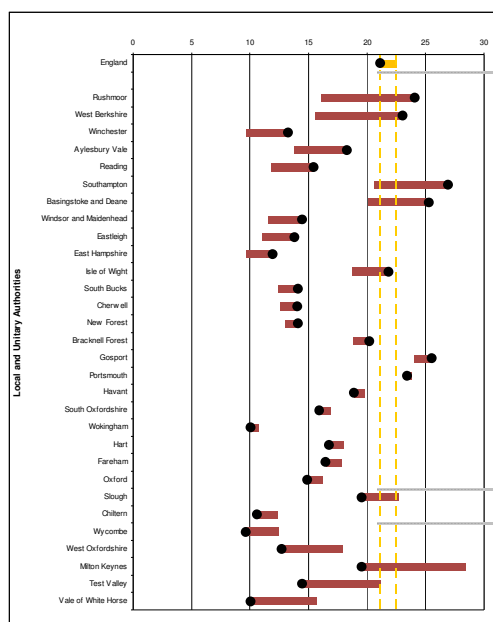
What this chart shows is that lung cancer has a significant impact on death rates in the most deprived parts of, in this case, Portsmouth. Conversely, work on colorectal cancer will have a far weaker impact on death rates in this area. This sort of information enables an informed discussion about where investment will have most impact.

These two tools will help highlight the areas that present the most immediate problems, but what they don't do is enable any comparison over time. Overall death rates from cancer are falling, and there has been real progress nationally. However, looking

at progress over time for specific cancers may give a very different story.

NCAT, the National Cancer Intelligence Network (NCIN) and the South West Public Health Observatory have produced charts that plot the movement in mortality rates for specific cancers over time⁸. These so-called 'rain drop' charts provide a dynamic view of which cancer mortality rates are improving and which are not. Lung cancer among women is a particular problem.

This chart shows changes in lung cancer mortality among women in the South Central area. The start of the brown line is where the age standardised mortality rate for females aged under 75 was between 1995 and 1997. The black blob is where it was in 2006-2008.



Where the black blob is on the left of the line, mortality is falling. When the blob is on the right, mortality is rising. In an alarming number of areas the mortality rates have risen. This may be the result of the increase in smoking among women in the 1960s.

Lung cancer has a social gradient – people in deprived areas have a higher rate of smoking⁹, which is the primary cause of the disease. Investigation of the dynamic of

⁸ Cancer Mortality Profiles: Raindrop chart spreadsheet, SWPHO <http://www.swpho.nhs.uk/resource/item.aspx?RID=76244>

⁹ *Equally Well: Report of the Ministerial Task Force on Health Inequalities - Volume 2* <http://www.scotland.gov.uk/Publications/2008/06/09160103/2>

cancer mortality might well highlight a particular problem that is not improving, or in some cases is getting worse – which the chart on the previous page shows is happening in more than half the PCTs in the South Central area.

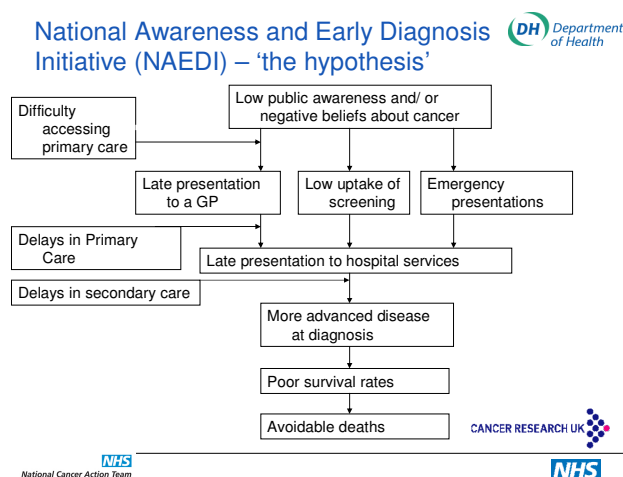
Regrettably, HINST has come across few examples where PCTs and local partnerships have measured differences in survival rates among different social groups – groups based on race, culture or sexuality for example – which could lead to more targeted intervention, perhaps building on the data about access by ‘equality group’ available for each PCT from NCIN¹⁰.

One area where different social groups have been identified separately is take-up rates for screening¹¹. Once a particular group has been identified that is not taking up invitations for screening, the problem can be defined and possible causes identified in a way that may reveal a pathway to a solution.

Step 2: Understand the reason for the problem

(Expressed Demand; Responsive Services; Local Service Effectiveness)

HINST has worked with the National Awareness and Early Diagnosis Initiative (NAEDI) hypothesis that the high rate of avoidable deaths from cancer in England is due to people being diagnosed with cancer when their tumour is at a stage when life-saving (usually surgical) treatment will not contain its impact and spread. The delay can happen at a number of points.



Information about the stage of development of the cancer when it is diagnosed is critical to understanding whether there is delay in people going to their GP or in their being referred on to a specialist. HINST describes these two steps as ‘Expressed Demand’ and ‘Responsive Services’.

¹⁰ NCIN – via webpage <http://www.ncin.org.uk/equalities/>

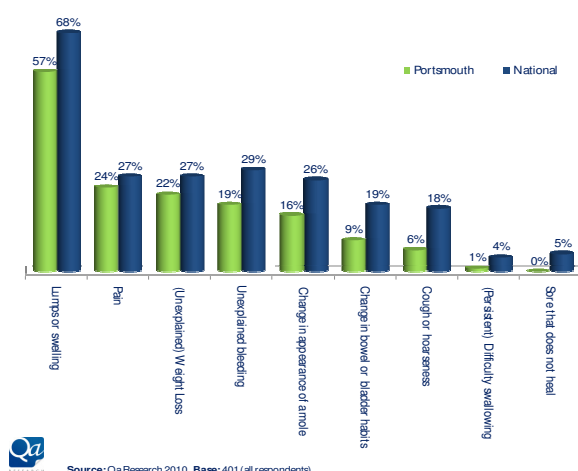
¹¹ Toni Mathie, Network Director, GMCCN 13th January 2007
http://www.gmccn.nhs.uk/hp/portal_repository/files/Item6.1bHealthInequalities-HealthyCommunitiesCollaborative.pdf.

'Staging data' is not yet easily available, but there has been progress in a number of networks which are setting the standard for others – most notably in the East of England. Delay in the collection and publication of data is a national problem highlighted by the National Audit Office¹².

Until up-to-date staging data is available, one-year survival rates can be used as a proxy for when people are being diagnosed late. One-year survival rates may give an insight into whether some groups of people are experiencing worse survival than others: whether by tumour site, geography, social group/cultural community, age, gender or disability. Cancer networks, working with the Cancer Registries, are the key to this intelligence. A number of networks have been able to identify that particular groups are coming forward late, and have then commissioned research to find out why.

I Expressed Demand

An important tool here is the Cancer Awareness Measure, (CAM)¹³, developed by three academic departments funded by Cancer Research UK (CRUK). The CAM is a standard set of questions that can be used in surveys and focus groups to identify whether people are less aware of cancer symptoms than is usual in the wider population.



This chart shows the results of an analysis by the Central and South Coast Cancer Network¹⁴ that found there is a problem with levels of awareness of symptoms of cancer in Portsmouth.

The CAM can also be used to find out why people are not coming forward to their GP in time. This may be due to practical issues – such as how hard it seems to make an appointment or get to the surgery;

low expectations of services; or people's feelings: low self-esteem, embarrassment or fear.

In County Durham and Darlington four cancers account for half of all early deaths and their contribution to excess mortality is about half as much again as the average for similar areas of high deprivation and poor health. The CAM was used to identify whether some of this might be linked to low awareness of cancer¹⁵.

¹² National Audit Office, (HC 568 2010-2011), *Delivering the Cancer Reform Strategy* http://www.nao.org.uk/publications/1011/cancer_reform_strategy.aspx

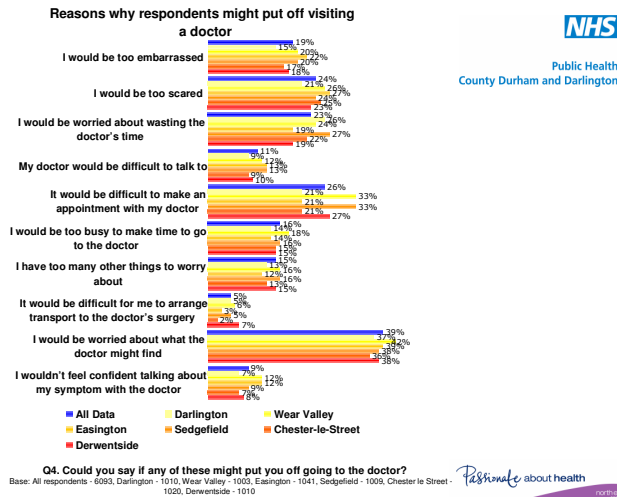
¹³ Stubbings S et al, *British Journal of Cancer* (2009) 101, S13-S17, 'Development of a measurement tool to assess public awareness of cancer.'

Practical information about the CAM is available via the CRUK website:

http://info.cancerresearchuk.org/spotcancerearly/naedi/AboutNAEDI/Researchevaluationandmonitoring/naedi_cam/

¹⁴ Sally Stanley at the Central and South Coast Cancer Network

¹⁵ Fiona McQuiston and Robert Armstrong — contact Fiona McQuiston, Macmillan information manager and health improvement lead



The chart shows subtle differences between neighbouring areas (formerly districts) in the same county.

The largest category is patients who were worried about what their doctor might find.

Since the initial surveys were carried out a number of site specific measures have also been completed – including Breast, Bowel, Cervical, Lung and Ovarian CAMs. These were developed with the support of Breakthrough Breast Cancer, Breast Cancer Care, Cancer Research UK, Ovarian Cancer Action, The Eve Appeal, Ovacom, Target Ovarian Cancer and DH¹⁶

Cancer is generally still regarded by a significant part of the population as a death sentence, and relatively few people are aware of the chances of survival with good quality of life, and even ‘cure’, particularly when detection is early, and treatment prompt. Cancer Research UK has undertaken research¹⁷ into this area with the ‘Fear survey’ and found that lower socio-economic groups are more afraid of cancer than higher socio-economic groups and more likely to think that whether or not you get cancer is down to fate.

Personal attitudes are also crucial to understanding why people are not taking up invitations to be screened. The local authority in Portsmouth¹⁸ has undertaken work using focus groups to find out what is holding people back – in this case why young women in Portsmouth were not having cervical smears. The research revealed some basic issues that could be solved with practical action – such as developing a protocol about who is allowed to enter the consultation room when a smear is being taken.

The key here is understanding who the target population is and what they think and feel, to ensure that they can be engaged with and encouraged to go to their GP earlier. Social marketing techniques can be very useful here, and the crucial point is that the expensive preliminary work does not have to be repeated by every district, but can be shared across cancer networks. The HINST/NCAT visit to the North of England Cancer

¹⁶ see http://info.cancerresearchuk.org/spotcancerearly/naedi/AboutNAEDI/Researchevaluationandmonitoring/naedi_cam/

¹⁷ Cancer Research UK, 8th December 2010 <http://info.cancerresearchuk.org/news/archive/pressrelease/2010-12-08-cancer-is-biggest-fear-but-some-think-it-is-fate>

¹⁸ Portsmouth ‘Ladies Lounge’ project <http://www.portsmouth.nhs.uk/Default.aspx?LocID=01pnew024.RefLocID=01p002001.Lang-EN.htm>

Network found that there is a plan to share social marketing insights in this way¹⁹. Cancer Research UK has published a useful guide to scoping social marketing campaigns²⁰.

The Manchester Versus Cancer Alliance was a partnership between the Greater Manchester and Cheshire Cancer Network, the Greater Manchester Public Health Network, and the Association of Greater Manchester PCTs that undertook the ‘Don’t be a cancer chancer’ campaign. This was a programme to raise awareness of the symptoms of different cancers in people over the age of 50 in three North West districts in 2008/ 09²¹. The Network co-ordinates news about initiatives through its website and through Facebook²².

An important step in tackling fear is presenting positive images of people’s experience of surviving cancer. HINST’s experience of this varied markedly across the country, but a number of places, such as Rochdale, had made some impact by using survivors to convey the message that cancer can be cured if it is caught early enough.

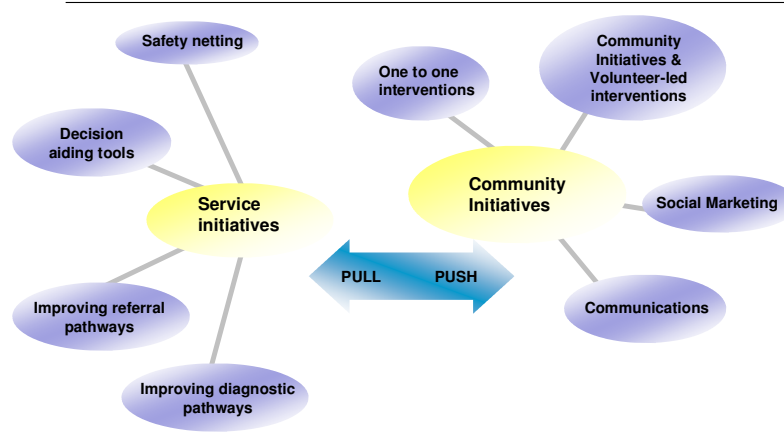
Social marketing provides a key to engaging with local populations to help people reconsider and change the way they feel about issues. National pilots in lung and colorectal cancer are currently underway and NAEDI has published a guide to using social marketing interventions to support local work.²³

II Responsive Services

Encouraging people to go to their GP sooner will only lead to earlier diagnosis if primary care is responsive when they arrive, people are not turned away and GPs don’t delay in referring them on to specialists or for tests.

NAEDI has highlighted different approaches grouped around these two themes – community based initiatives and service based initiatives.

Interventions for Awareness & Early Diagnosis



¹⁹ For more information contact Jo.Preston@sotw.nhs.uk

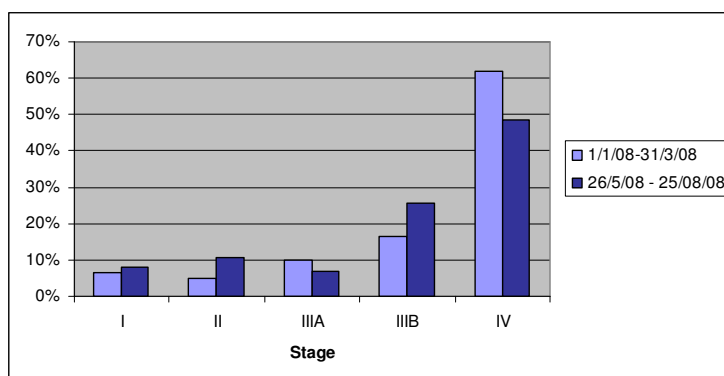
²⁰ tips on gathering information and insight, and links to sources such as the Healthy Foundations Segmentation model is available via <http://info.cancerresearchuk.org/spotcancerearly/naedi/local-activity/social-marketing/How-to-run-your-intervention/Scoping/>

²¹ Don’t be a Cancer Chancer website <http://www.cancerchancer.com/>

²² Greater Manchester and Cheshire Cancer Network <http://www.gmccn.nhs.uk/CancerInfo/News/CancerNews>

²³ <http://info.cancerresearchuk.org/spotcancerearly/naedi/local-activity/social-marketing/How-to-run-your-intervention/Implementation/>

This twin track approach underpins the Early Lung Cancer Intervention in Doncaster ('El Cid'), which led to an increase in the ratio of patients diagnosed at stages I & II from 11% to 19% as a result of a combined initiative to bring people forward with symptoms earlier and to encourage GPs to refer them on earlier²⁴.



Comparison of stage of diagnosis of lung cancer with previous year
Doncaster El Cid initiative

The 'Christmas Tree' model used by HINST emphasises that responsive services are just as important as raising awareness, and the early development of this model in South Yorkshire influenced the Doncaster initiative.

The crucial issue here is whether GPs work with patients to recognise early symptoms, and refer on appropriately for further investigation – the threshold at which their gate-keeping role is set. NICE has developed guidelines for lung cancer that recommend that people who have had persistent new chest symptoms for three weeks or more are referred for chest x-ray. This has met with opposition from GPs who may be concerned that this will be too costly, create an unmanageable level of demand or cause unnecessary potential harm through radiation. These objections are convincingly addressed in a presentation to a Cancer Research UK event pooling information about approaches to combating lung cancer²⁵, illustrating for example that a chest x-ray costs £20 and gives less radiation than a week's holiday in Cornwall.

If resistance from GPs to referring patients for tests is to be overcome, and the capacity in the system to accommodate them is to be ensured, the emerging GP Commissioning Consortia will need to embrace this work together with their Health & Wellbeing Boards. HINST came across only one example where a PCT had recognised the need to develop protocols systematically and sensitively by bringing GPs and hospital consultants together to support change in practice within a supportive learning environment – North East Lincolnshire's lung cancer referral protocols. A published article on the subject highlights the importance of 'conversion rates' in measuring whether GPs are identifying more patients with cancer and making more accurate referrals²⁶.

NCAT, working with national NAEDI partners, has sponsored an enormous body of research and practical guidance into supporting GPs to review referral that Boards need to be aware of, but which falls outside the scope of this guide. Projects in 2010/11 are

²⁴ Suckling R, May 2010, *Early Lung Cancer Intervention in Doncaster: Doncaster 3 Week Cough: How To Guide*, NHS Yorkshire and the Humber, NCAT and NHS Doncaster.
http://info.cancerresearchuk.org/prod_consump/groups/cr_common/@nre/@hea/documents/generalcontent/cr_043172.pdf

²⁵ Callister M, Consultant Chest Physician Leeds Teaching Hospitals NHS Trust, presentation available via CRUK <http://info.cancerresearchuk.org/spotcancerearly/naedi/local-activity/social-marketing/How-to-run-your-intervention/Evaluation/lung-cancer-workshop/>

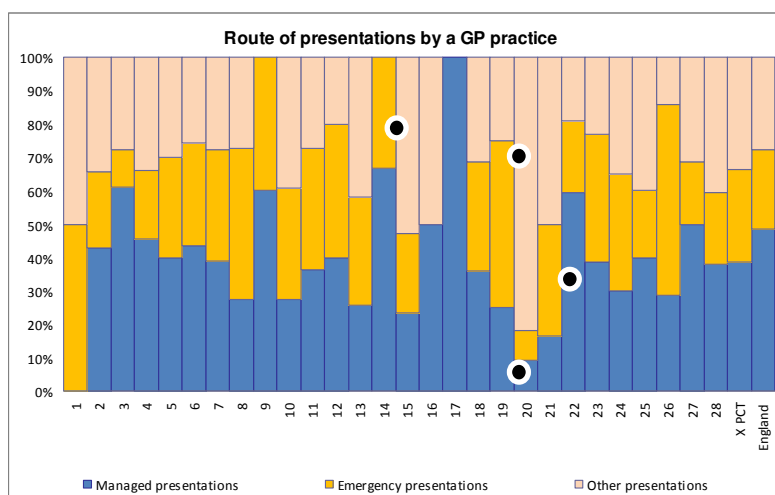
²⁶ Twomey P, 2006, 'Implementation of national cancer guidance: the experience of one primary care trust', *Quality in Primary Care* 2006; 14: pp 185-192

focusing on the Royal College of General Practitioners (RCGP)/NCAT National Audit of Cancer Diagnosis in Primary Care, the use of GP Practice Profiles, piloting the use of a Risk Assessment Tool; clinical engagement in the NAEDI Regional Communications Pilots and local initiatives; use of practice systems such as safety netting; and sharing good practice from local interventions or service changes. More information is available through cancer networks or NCAT²⁷.

There is a wealth of information about referral rates from individual practices that will help to identify how they can share effective practice among peers – to ensure that when patients attend with symptoms they are referred on for treatment, in time for it to be effective. The primary source is the National Cancer Information Network’s Cancer Commissioning Toolkit (CCT)²⁸.

GP Practice Profiles are being made available to practices in pdf format, as well as through the CCT. Cancer Networks, through their GP leads, are reviewing the information with practices and offering targeted support including the RCGP/NCAT Cancer Diagnosis in Primary Care Audit. With GPs and PCTs, Cancer Networks will be helpful in sifting and interpreting this information, and highlighting where outcomes are significantly different, for practices to consider why, in dialogue with their peers – particularly those practices, which are achieving better outcomes.

HINST has begun to collate this information to demonstrate the sort of real variation that exists, and encourage networks to highlight the impact on inequalities as they engage with GP Commissioners to agree actions that need to be taken locally. This chart shows where variations are significant (dotted).



A large number of initiatives are under way that will impact on raising awareness and earlier diagnosis. Networks can provide a useful function here by mapping what is already happening before Health and Wellbeing Boards commit to action – as happened with the Greater Manchester and Cheshire Cancer Network²⁹.

In forming a view of what is causing more people to die earlier from cancer in the most deprived areas, Boards may want to review the whole system of demand for and the

²⁷ NCAT – Diagnosing Cancer Earlier – Primary care
<http://www.ncat.nhs.uk/our-work/diagnosing-cancer-earlier/primary-care>

²⁸ The log-on page for this toolkit is
<https://www.cancertoolkit.co.uk/PublicPages/Login.aspx?ReturnUrl=%2fPages%2fPracticeProfiles.aspx>
 but Boards will need to have an account, to be approved by their local cancer network

²⁹ For an account of the work of the Network in mapping work in progress see
<http://info.cancerresearchuk.org/spotcancerearly/naedi/local-activity/getting-results/commissioners/Mappingprojects/>

for a copy of the report by Rona Cruikshank go to:
http://info.cancerresearchuk.org/prod_consump/groups/cr_common/@nre/@hea/documents/generalcontent/cr_046923.pdf

supply of cancer services. HINST uses a model³⁰ that separates out 13 aspects of the demand for services, their structure and delivery and the management and networking of commissioning. This 'Christmas tree' model provides the framework for the workbook³¹ that is used to structure the workshops and a summary is included here as an appendix.

'Understanding the reason for the problem' necessitates Boards working closely with GP Commissioners, advised by their Cancer Network, to ensure that people are coming forward at an early enough stage to be treated successfully with high quality services.

³⁰ Department of Health, 2008, *Systematically Addressing Health Inequalities*, Gateway reference 10060
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_086573.pdf

³¹ *The HINST Cancer workbook has not yet been published, but when it is it will be on the HINST website or signposted from there www.dh.gov.uk/HINST*

Step 3. **Act, Monitor and Evaluate**

(Engaging the public; networks; leadership and co-ordination; cost effectiveness; adequate service volumes; balanced service portfolio)

HINST has predicted, and subsequently observed, that for action to make an impact at a population level, it needs to be systematic and resourced at the right scale. The elements to this step are common to all successful health commissioning, so they are not explored in depth here, but they are included because of their importance.

Over the past few years PCTs have been on firmer ground in justifying initiatives to reduce excess mortality from heart disease than from cancer because the evidence base and cost effectiveness research that is needed to construct a business case is more extensive. This is changing, and the evidence base of interventions used by HINST³² is now beginning to include interventions on cancer. However, population level approaches to cancer outcomes will only be systematically adopted by commissioners if interventions are evidence based and intelligence about their cost effectiveness is shared. A start has been made by the Department of Health³³.

The key steps that HINST has observed in implementing initiatives that reduce excess mortality from cancer are for commissioners, with service users, clinicians and the cancer network, to:

1. Construct a 'Plausible Hypothesis for Change' that identifies the problem and its causes, using epidemiological data and trend analysis, and specify the (quantified) outcome that partners will commit to
2. Research effective practice then appraise options (and include a cost benefit analysis in the option appraisal)
3. For population interventions – awareness raising among the public – segment the target audience and define the behaviours that need to be addressed through social marketing techniques and community engagement
4. For service interventions – develop support mechanisms and feedback loops between clinicians to continually improve practice
5. Model the impact on capacity and either invite to tender or recruit and retrain staff
6. Monitor, feedback and modify the intervention in response
7. Evaluate
8. Start again

It is important that examples of effective practice in this work are shared to avoid duplication of effort and minimise costs – possibly via NAEDI³⁴.

The following diagram was used at the HINST dissemination events in January 2011 to illustrate the process described in this report:

³² Department of Health, 2010, *How to model the scale of evidence-based interventions necessary to hit targets on reducing inequalities in life expectancy*, Gateway reference 13648
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115106.pdf

³³ Department of Health, 12th December 2010, *The Likely Impact of Earlier Diagnosis of Cancer on Costs and Benefits to the NHS*, Gateway reference 015375
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_123371?PageOperation=email

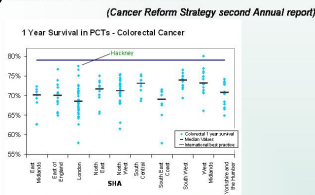
³⁴ <http://info.cancerresearchuk.org/spotcancerearly/naedi/AboutNAEDI/>

Health Inequalities National Support Team

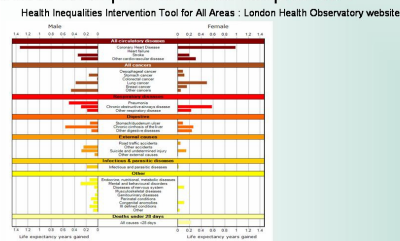
How to Reduce Excess Mortality from Cancer in the areas of highest deprivation and worst health

Step 1 : Define the problem

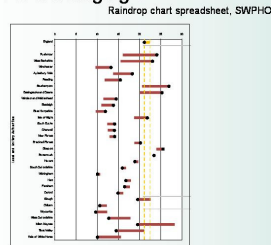
1 How do one year survival rates compare with neighbours / similar areas ?



1.i What is the impact on health inequalities ?

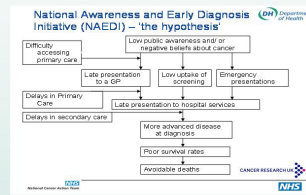


1.ii How is it changing ?

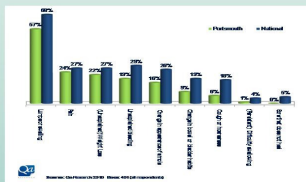


Step 2 : Understand the Reason for it:

2.i Where the delay is happening ?

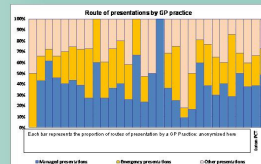


2.ii Why are people are not coming forward earlier ?



2.ii What is happening with GP referrals ?

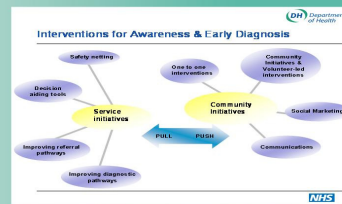
(Greater Manchester & Cheshire Cancer Network Review of referrals by Cancer type)



Step 3: Evaluate, Act & Monitor

Together with service users, clinicians and the Cancer Network:

1. Construct a 'Plausible Hypothesis for Change' that identifies the problem and its causes, using epidemiological data and trend analysis, and specify the (quantified) outcome that partners will commit to
2. Research effective practice then appraise options (and include a cost benefit analysis in the option appraisal)
3. For population interventions - awareness raising among the public - segment the target audience and define the behaviours that need to be addressed - through social marketing techniques and community engagement
4. For service interventions - develop support mechanisms and feedback loops between clinicians to continually improve practice
5. Model the impact on capacity and either invite to tender or recruit and retrain staff
6. Monitor, feedback and modify the intervention in response
7. Evaluate
8. Start again



NAEDI 2010

Web: www.dh.gov.uk/hinst | Email: peter.counsell@dh.gsi.gov.uk

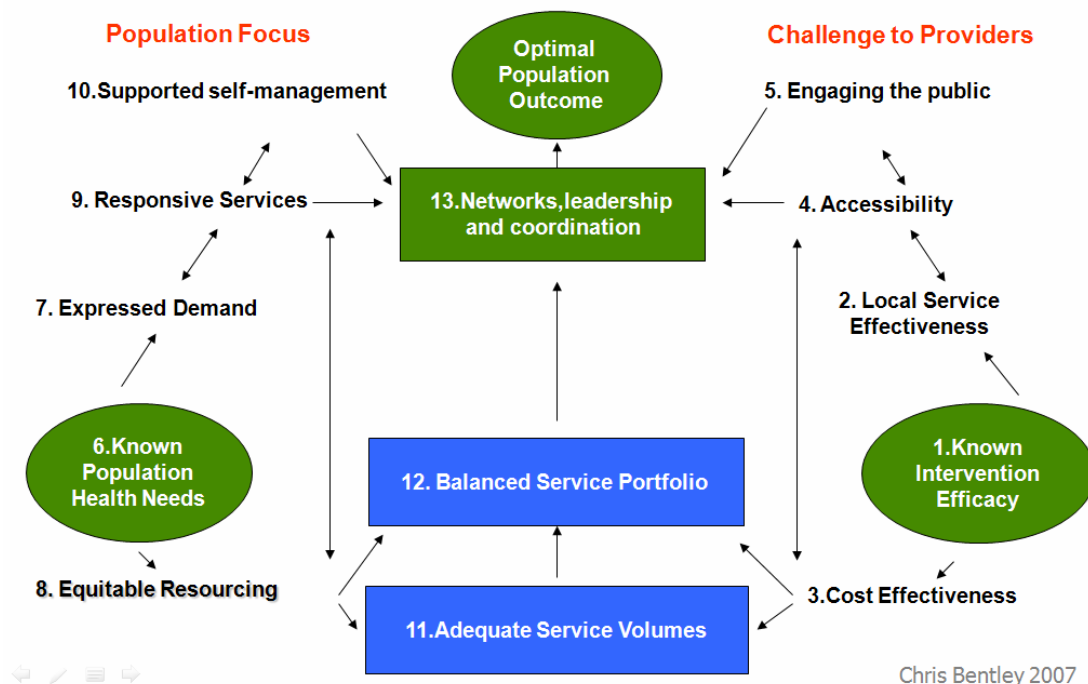
Appendix – The ‘Christmas Tree’ Model

The ‘Christmas Tree’ model is used by HINST in the diagnostic workshops it has held in areas of deprivation and poor health in England. It is a generic model that looks at the demand for services, the supply of services and the organisation of commissioning that is in operation in each workshop area. A workbook of the questions used is available as a separate resource³⁵.

There are 13 points on the model where things have to be working effectively to secure the optimal population outcome.

In relation to cancer, much attention has been focused on the left hand side of this diagram (factors 1-5), for instance through the Improving Outcomes Guidance (IOGs), and the central issues (factors 11, 12 and 13) particularly through the Cancer Waiting Times initiative. More recently the Cancer Reform Strategy has brought focus to the left hand side (factors 6 – 10), which addresses how the population uses services, and is supported to do so.

Commissioning for Best Outcomes



1. Known intervention efficacy - This is the only point of the Christmas Tree generic model not addressed in the cancer workbook because interventions for which there is strong evidence are already detailed in the Improving Outcomes Guidance on a cancer site specific basis. In the other HINST workbooks this section looks at the evidence base for ‘what works’.

³⁵ The HINST Cancer workbook has not yet been published, but when it is it will be on the HINST website or signposted from there www.dh.gov.uk/HINST

Appendix – The 'Christmas Tree' Model

2. Local Service Effectiveness - Ensuring that cancer networks, with Commissioners and clinicians, are achieving optimal service outcomes through their use of interventions, the use of audit and clinical governance to drive improvements and that education and training is being used systematically to support high standards of clinical effectiveness.
3. Cost effectiveness - Ensuring that programme elements are as affordable as possible at population level.
4. Accessibility - Ensuring that primary care and specialist services are designed with minimum barriers to access.
5. Engaging the Public - Ensuring users and potential users of service have meaningful input into their design, and efforts are being made to engage 'seldom seen seldom heard' elements of the population.
6. Known Population Health Needs - Ensuring that there is a realistic assessment of the size and nature of the cancer problem locally, and its distribution geographically and demographically.
7. Expressed demand - Ensuring that residents are enabled and supported to present for early diagnosis and treatment.
8. Equitable Resourcing - Ensuring that the disproportionately high cost of achieving equitable outcomes among communities with the greatest needs are recognised and met.
9. Responsive services - Ensuring that when patients present with suspicious signs and symptoms to primary care they are referred effectively for rapid diagnosis and treatment and receive culturally sensitive help to navigate to the relevant service.
10. Supported self-management - Ensuring that patients are educated and supported to make choices and manage their treatment to best effect.
11. Adequate service volumes - Ensuring adequate service volumes are commissioned, which take into account the drive to diagnose patients earlier.
12. Balanced service portfolio - Ensuring there are no bottlenecks and delays in patient pathways, including primary care, so that patients have fast access to high quality treatment for cancer, including surgery, radiotherapy and drug treatment.
13. Networks, leadership and coordination - Ensuring that commissioners and providers take population needs into account when planning and delivering services.