



North Central London
Health and Care
Integrated Care System



North Central London
Cancer Alliance



NCL Cancer Commissioning Guide & High-Level Intentions for 2025-26



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Cancer Commissioning

Introduction

The **North Central London Cancer Commissioning Guide & High-Level Intentions** document provides a comprehensive roadmap for the commissioning of cancer services across the region. It sets out the national and local strategic landscape, aligning with key NHS priorities to drive early diagnosis, improve patient outcomes and reduce health inequalities.

This document also outlines the high-level commissioning intentions for 2025/26. A key feature of this commissioning guide is the **NCL Cancer**

Commissioning Wheel, which clarifies the annual commissioning cycle, ensuring a structured, data-driven approach to service improvement. It outlines how services will be planned, delivered, and evaluated to ensure quality, innovation and sustainability.

Recognising the need to future-proof cancer services, this commissioning guide integrates a **methodological framework** for reviewing fragile services. Developed through extensive stakeholder engagement—including one-to-one consultations, expert reference groups and collaborative workshops—the fragile services framework provides a structured approach to identifying areas of service vulnerability, assessing risks and implementing targeted interventions.

Through the integration of evidence-based commissioning, financial sustainability measures and strategic workforce planning, this commissioning guide outlines how cancer services in North Central London will remain patient-centred, high-performing and resilient in the face of evolving healthcare demands.

NCL Cancer Alliance Strategic Aims

1. Improve **Survival** (SA1): Prioritise early diagnosis, intervention, and prevention.
2. Enhance **Patient Experience** (SA2): Deliver the highest standards of patient care and improve quality of life.
3. Operational **Efficiency** (SA3): Ensure sustainable, innovative cancer diagnostic and treatment services.
4. Address Health **Inequalities** (SA4): Reduce disparities in access and outcomes across all population groups.
5. **Workforce** Excellence (SA5): Ensure that we have a well-trained, competent workforce delivering high-quality care.
6. Foster **Innovation** (SA6): Promote innovative approaches in cancer diagnostics, care, and treatment.

The Role of Commissioning

Commissioning plays a pivotal role in facilitating the delivery of high-quality, sustainable cancer services that continue to meet the evolving needs of patients and communities. Through robust commissioning practices, we can ensure that resources are allocated effectively and services are designed to achieve maximum impact.

Definition: Commissioning is the process of assessing needs, planning, prioritising, purchasing and monitoring health services to ensure the best possible outcomes for patients.

Commissioner Code: “To ensure equitable access to services and equitable opportunity of outcomes for all.”

Key Benefits of Commissioning

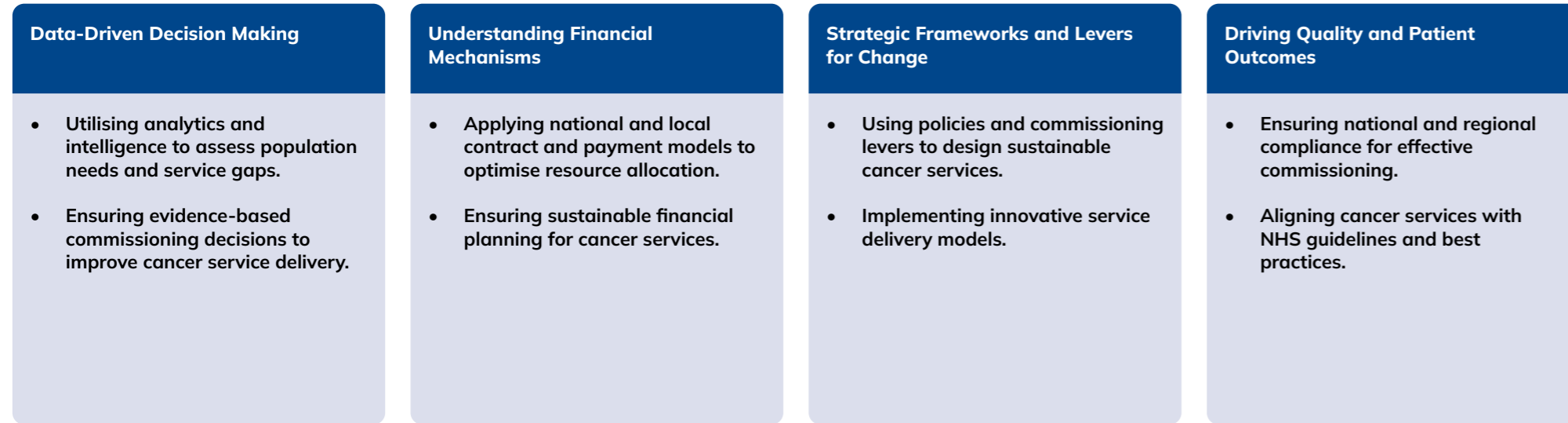
- Driving Quality and Patient Outcomes**
 Setting clear service specifications ensures adherence to clinical guidelines and best practices, leading to better patient outcomes.
- Fostering Innovation**
 Promotes cutting-edge technologies and innovative care pathways, keeping cancer services at the forefront of advancements.
- Safeguarding Sustainability**
 Ensuring services are fit for purpose, there is alignment between demand and capacity, together with adequate resources such as workforce and funding supports continued sustainability.
- Addressing Disparities**
 Reduces health inequalities by prioritising underserved populations and addressing barriers to access.

Understanding the Full Spectrum of Healthcare Commissioning

Commissioning includes a range of functions from the operational “nuts and bolts” through to strategic commissioning which encompasses strategic planning for the populations healthcare needs, horizon scanning and embedding clinical and operational innovations into healthcare services.



Cancer Commissioning: Key Responsibilities



Cancer commissioning operates within a multi-tiered system, integrating national directives with regional and local strategies:

- National Landscape:** Policies, frameworks, and funding initiatives set by NHS England, NICE guidelines and national cancer strategies guide service design and expectations.
- Regional and Local Landscape:** Integrated Care Boards (ICBs), Cancer Alliances, and Local Health Systems tailor national priorities to address regional disparities, workforce capacity and population health needs.
- Financial and Contractual Mechanisms:** Payment models, tariff structures, and commissioning frameworks determine the funding and sustainability of cancer services.

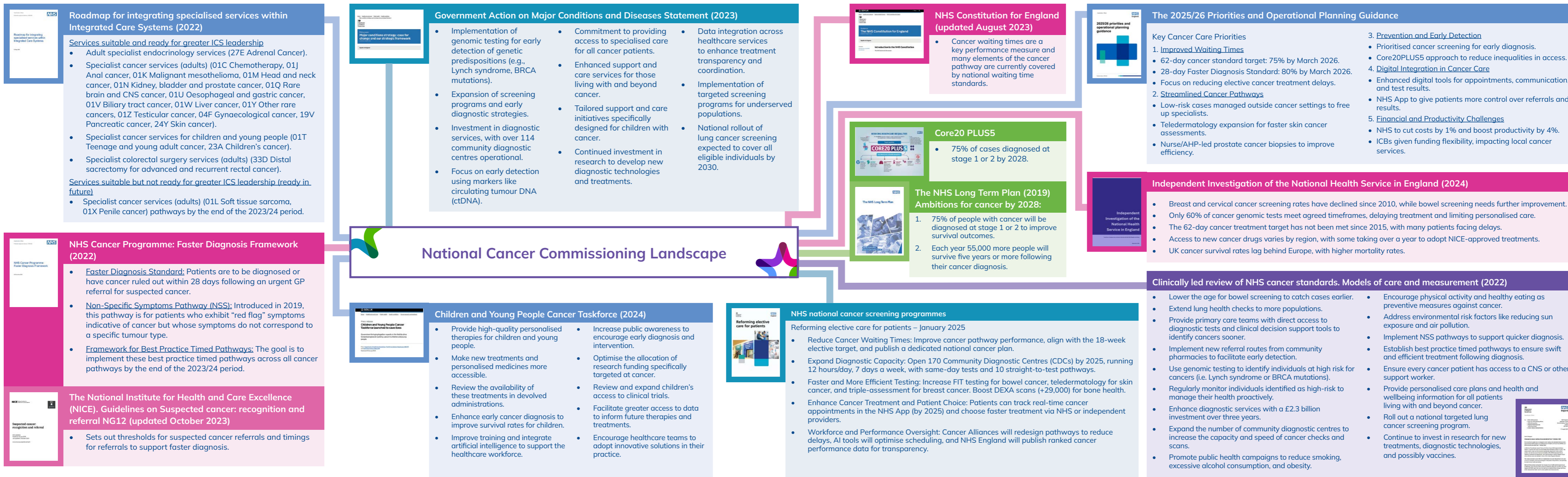
By analysing these landscapes, commissioners can identify service gaps, prioritise investments and implement change effectively.

Fragile Services Framework

- In order to support a strategic review of fragile cancer services, we have developed a fragile services framework to identify and assess areas of fragility within cancer services. The framework comprises several domains (please see appendix 3 for further detail).
- We have constructed a **Two-Tier Approach**. With clinical and operational teams undertaking a **simple high-level assessment** (see appendix 4) to identify areas of risk or opportunity. This is followed by a **detailed review** of identified concerns, supported by relevant quantitative and qualitative data.
- Stakeholder collaboration will be key to understanding areas of fragility, identifying opportunities and solutions and prioritising and setting the strategic direction.
- The “Fragile Framework” review process will be undertaken annually. The outputs of which will feed into the annual commissioning work-programme. In 2025/26, the key themes will also feed into the **NCL Cancer Commissioning Strategy**.
- The fragile services framework will be embedded into **NCL’s Annual Commissioning Cycle**. This cyclical process ensures NCL can adapt plans as required to ensure continued high-quality, equitable and sustainable cancer care across NCL.

Please see **Appendices 2-4** for further detail.





This will be updated following the publication of the NHS 10-Year Plan (Spring 2025) and the National Cancer Plan (Summer 2025) to reflect any changes in strategic priorities and operational guidance.

Cancer Patient Experience Survey, 2023 Results.North Central London Cancer Alliance. Published July 2024

- Questions above expected range - Q58. Cancer research opportunities were discussed with patient.
- Questions below expected range - Q6. Q8. Q12. Q16. Q18. Q20. Q28. Q39. Q44. Q50. Q51. Q53.

North Central London Population Health and Integrated Care Strategy (2023)

Strengthening Integrated Delivery

- Develop MDTs within PCNs with community and secondary care support to reduce waiting lists.
- Integrate health and social care teams for joint triage and create networks for MDTs to support complex needs across GP practices.

Personalised Care

- Enhance personalised care planning for cancer patients.
- Develop digital support for proactive home care.

Collaborative Efforts

- Strengthen engagement with VCSE sectors.
- Make social prescribing visible, accessible, and available.

Population Health Management

- Integrate cancer data with wider health determinants.
- Embed health inequality indicators in performance metrics for equitable cancer care.

Prevention and Early Intervention

- Expand the Health Inequalities Fund to scale interventions reducing cancer care disparities.
- Focus on prevention, early intervention, and proactive care to improve cancer outcomes.
- Raise awareness and educate on cancer prevention and early detection with community organisations and health campaigns.

Addressing Health Inequalities

- Implement recommendations from the NCL Inclusion Health Needs Assessment to serve underserved populations.

North Central London Primary Care Cancer Strategy (2022-25)

Key Theme 1

- Reducing variation and Health inequalities across NCL.

Key Theme 2

- Basing cancer care practice on data and analytics.

Key Theme 3

- Optimizing cancer screening uptake (concentrating on breast and cervical).

Key Theme 4

- Enhancing a culture of learning and development.

Key Theme 5

- Creating a community of practice.

Key Theme 6

- Contribute to the operational performance of the overall cancer pathway.

2024/25: Cancer Alliance Planning Pack (2024)

Faster Diagnosis and Operational Performance:

- Faster Diagnosis Priority Pathways – Skin, Gynaecology, Urology, Breast.

Early Diagnosis:

- Targeted Lung Health Checks (TLHC).
- Multi-Cancer Blood Test Programme (formerly Galleri Interim Implementation pilot).
- Faecal Immunochemical Testing (FIT).
- Liver Surveillance.

Liver Pilots.

- Community Pharmacy Pilots.
- Pancreatic Cancer.

Local Early Diagnosis Initiatives:

- Screening.
- Timely Presentation.
- Primary Care Pathways.
- Innovation.
- Health Inequalities.

Treatment and Care:

- Treatment Variation.
- Living With and Beyond Cancer.
- Experience of Care.

Cross-Cutting:

- Workforce.
- People and Community.
- Engagement.

NCL CANCER ALLIANCE STRATEGIC AIMS 2023-28

SA1. Improve survival, focusing on early diagnosis, and prevention

SA2. Deliver the highest standards of patient experience and improve quality of life

SA3. Support the operational delivery of high performing, innovative and sustainable cancer diagnostic and treatment services

SA4. Reduce health inequalities across our whole population

SA5. Ensure we have the right workforce in place and that we deliver the highest standards of staff experience

SA6. Foster innovative approaches and practice in cancer diagnostics, care and treatment

North Central London Cancer Prevention, Awareness and Screening (2023-28)

All Cancers. Increase Screening Uptake: Engage PCNs with low screening uptake. Utilise community engagement and social media to raise awareness. Embed cancer awareness in Making Every Contact Count (MECC) training.

Specific Cancer Types:

- Bowel Cancer: Support the bowel screening age extension to 50 years. Integrate Lynch Syndrome pathway into bowel cancer screening. Develop targeted communications to improve awareness and participation.
- Breast Cancer: Implement call and recall systems to improve screening uptake.

Specific Initiatives

- Cervical Cancer: Support the roll-out of HPV self-sampling. Increase HPV vaccine uptake among school-aged children. Extend screening recall frequency.
- Lung Cancer: Expand Targeted Lung Health Checks to cover the full population. Increase participation, especially in deprived areas.
- Community Engagement: Collaborate with local authorities, VCS organisations, and community groups to disseminate information. Design activities for delivery through community pharmacies.
- Targeted Campaigns: Utilise resources to target specific demographics (e.g., BAME, people with learning disabilities, severe mental illness).
- Training and Education: Update MECC and other education packages to address population needs. Promote MECC training across the sector.

Develop a network of champions to promote breast screening. Transition to electronic results sharing with GP practices.

North Central London Cancer Alliance Acute Diagnostics and Treatment Delivery Group (ADTDG) (2024)

1. **FIT (Faecal Immunochemical Testing).** Evaluate pathway impact and decide on future delivery in primary or secondary care.
2. **Treatment Variation.** Focus on existing pathways (Lung, Breast, Prostate, Bowel) and expand as needed. Add new pathways, including oesophago-gastric cancer and SACT service evaluations.
3. **Breast Pain.** Implement sustainable breast pain pathways across all providers by Q4 24/25.
4. **Skin 2nd Tele dermatology.** Roll out tele dermatology services across all USC skin pathway providers by June 2024. Ensure services are commissioned as BAU by March 2025.
5. **Lynch Syndrome.** Provide oversight and support for Lynch Syndrome services, including a surveillance hub pilot at UCLH.
6. **Non-Specific Symptoms (NSS).** Support full commissioning of NSS pathways by Q4 24/25.
7. **Colon Capsule Endoscopy (CCE).** Evaluate CCE effectiveness and support providers wishing to continue the service.
8. **Breast Outcomes.** Conclude the project by Q4, with oversight moving to the Breast ERG.
9. **Liver Surveillance.** Establish a baseline and implement quality improvements across providers. Implement national minimum standards for hepatocellular carcinoma surveillance pathways.
10. **Recording BPTP Milestones.** Continue collecting BPTP data to monitor colorectal and prostate diagnostics waiting times.
11. **COSD/Staging Completeness.** Support providers in meeting national data completeness standards and facilitate shared learning.
12. **MDT Optimisation.** Develop and implement care standards for MDTs across the sector.
13. **Admin and Clerical Workforce.** Conduct biannual audits of the cancer MDT Coordinator workforce.
14. **Patient Engagement and Involvement and Experience of Care.** Seek patient representation in each ERG and involve patients in pathway changes.
15. **Clinical Networks.** Maintain existing ERGs and fund Network Directors.
16. **Research.** Support existing research projects within the ADT programme.
17. **Low Volume High Risk Pathways.** Maintain oversight of low volume cancer pathways and engage with Network and medical directors to address issues and opportunities.

North Central London Workforce Strategy (2023)

Ensure Sufficient Workforce Capacity and Optimise Allocation

- Collaborate with educational providers for adequate workforce capacity.
- Offer apprenticeships for entry into health and social care.
- Provide local job opportunities with flexible employment models.

Develop the Right Skills and Expertise

- Support career development in cancer care.

Enhance Quality and Safety and Improve Patient Experience and Outcomes

- Use technological advancements to improve cancer care.
- Boost productivity with digitally enhanced pathways.
- Move towards an integrated workforce model for holistic cancer care.

Promote Collaboration

- Foster inclusion and meaningful contribution in the cancer care workforce.
- Encourage collaboration among healthcare providers across sectors.

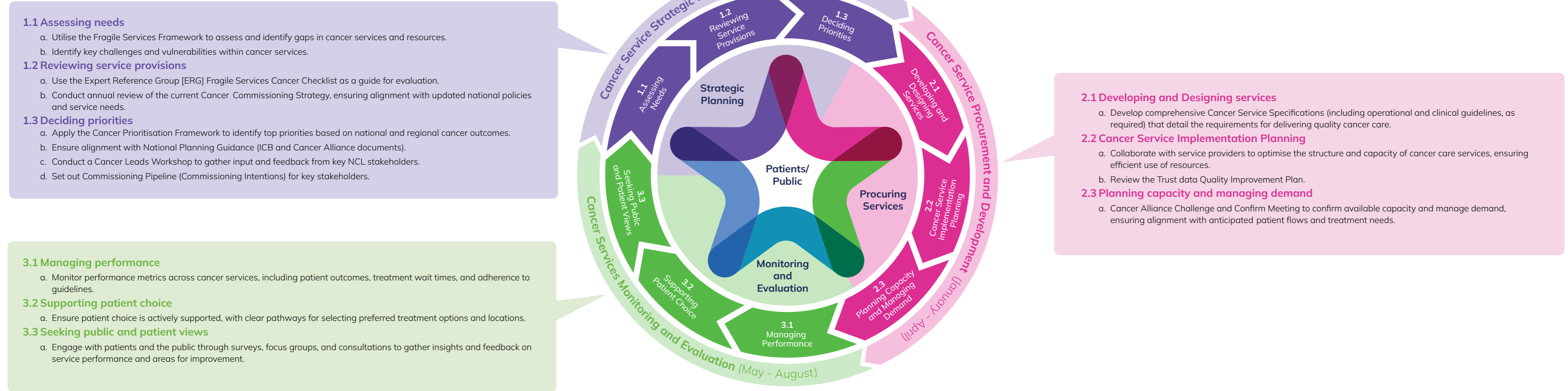
Develop advanced clinical practice roles alongside generalist roles.

Emphasise digital, data-focused roles and technology innovations.

Documents awaiting publication. GP Direct Access Diagnostics for people not meeting NG12, Workforce Strategy, Radiotherapy Workforce and Equipment Strategy

NCL Cancer Commissioning Cycle

The NCL Cancer Commissioning Cycle is a framework that outlines the iterative process of commissioning, encompassing strategic planning, procuring services and monitoring outcomes. It ensures that services are continuously evaluated and adapted to meet evolving needs. The cycle integrates input from patients and the public at every stage, ensuring that commissioned services reflect their needs and preferences.



Cancer Commissioning Intentions*

High-Level Indications for 2025-26

Cancer Commissioning Strategy	Earlier Diagnosis	Personalised Care	Acute Diagnostic and Treatment
<p>To develop a 5 year Cancer Commissioning Strategy. Identifying areas of fragility within cancer services, including those elements of services which have been delegated or not, through implementation of the “NCL Fragile Cancer Services Framework” and through stakeholder engagement setting out the strategic direction, and priorities, for cancer commissioning in NCL.</p>	<p>Development of a tariff or alternative funding mechanism, to support the substantive commissioning of surveillance services across NCL.</p> <p>Lynch Syndrome Surveillance Hub Innovative Pilot in place. Funded for a second year with non-recurrent funding to provide additional evidence and undertake engagement to move the pilot into a sustainable position.</p> <p>Ovarian Surveillance Hub Modelling underway to understand resource implications for ovarian surveillance pathway for BRCA1 and 2 ; ROCA testing pathway (non-recurrent cancer transformation funding) for patients on a waiting list for risk reducing surgery to commence Q1 25/26.</p> <p>Commissioning Route: Business case outlining proposal for sustainable commissioning of these services under development.</p>	<p>Lymphoedema Service Provision NCL system wide service spec. developed for embedding into NCL provider contracts in 25/26. Support will be provided during 25/26 to RFL Trust and Charity to develop and implement lymphoedema offer for Barnet.</p> <p>Commissioning Route: Acute Trust provision within tariff; Community provision via community core offer.</p> <p>Move4You Programme Will require legacy planning to mitigate risks of service not being re-commissioned. Further information regarding prehab and rehabilitation programme to follow.</p> <p>Psychosocial Support Services Develop service specification to be embedded into future contracts. Support providers to develop necessary business cases for acute and community providers for sustainable delivery of psychosocial support services and delivery of the Cancer Alliance integrated psychosocial pathway.</p>	<p>Breast Hormone Pathway Consistent pathway for NCL developed. Prioritises option for patient self-admin or in a primary care setting with secondary care keeping clinical responsibility.</p> <p>Commissioning Route: Although the pathway addresses current inequity, limited 5 year savings have been identified, impeding system ability to move from secondary to primary care setting. Alternative options being explored.</p> <p>Telederm Develop NCL clinical pathway, service spec, clinical and operational guidelines; Implement pathway - NMUH, UCLH, RFL, WH.</p> <p>Breast Pain Clinical pathway, service spec, clinical and operational guidelines to be documented; Implement pathway - NMUH, UCLH, RFL, WH.</p> <p>Commissioning Route: Commissioned via current tariff. Anticipate a national tariff for image acquisition and reporting.</p>

*Please see Appendix 1 for a more detailed Implementation Plan

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North Central London Cancer Commissioning Strategy 2025-2026 Implementation Plan

1. CANCER COMMISSIONING STRATEGY INITIATIVES	MILESTONES	CANCER ALLIANCE STRATEGIC AIM ALIGNMENT
<ul style="list-style-type: none"> A. Fragile Service Review B. Specialised Commissioning Delegation C. Cancer Commissioning Strategy 	<ol style="list-style-type: none"> 1. ERG's to complete the "Tumour Specific Cancer Fragility Checklist" baseline assessment. To include Specialised Commissioning, delegated elements of cancer services such as specialist surgery. Q1 25/26 2. Gather data to support a strategic review of fragile cancer services, as identified following the baseline assessment. Q2 25/26 3. Launch a "call to action" exercise with partners to identify levels of appetite to support critical areas. Q2 25/26 4. Undertake stakeholder engagement, to identify key goals and priorities for cancer services transformation requirements. Q2 25/26 5. Update the national and regional cancer landscape analysis to incorporate key deliverables from ten-year plan (published Spring 2025) and cancer plan (published Summer 2025) Q3 25/26 6. Develop a 5-year cancer commissioning strategy for NCL, aligned to clinical priorities identified via the fragile services review. Q3 25/26 	<p>SA1, SA2, SA3, SA4, SA5, SA6</p>

2. EARLIER DIAGNOSIS INITIATIVES	MILESTONES	CANCER ALLIANCE STRATEGIC AIM ALIGNMENT
<p>A. Surveillance Service Model Development</p>	<ol style="list-style-type: none"> 1. Development of a tariff or alternative funding mechanism, to support the substantive commissioning of surveillance services across NCL. Q1 25/26 2. Identify a list of potential surveillance services for NCL. Undertake analysis to ascertain impact for each of these, specifically potential for avoiding cancer/earlier diagnosis, and work with ICB to agree commissioning approach for each of these. Q3-4 25/26 3. Roll out surveillance services comms and education programme across NCL. Q3-4 25/26 	<p>SA1, SA4</p>
<p>B. Lynch Syndrome (LS) Surveillance</p>	<ol style="list-style-type: none"> 1. Finalise modelling and business case and take through ICB governance process to ensure sustainability of the LS hub service in NCL. Q1 -2 25/26 2. Sustainably commissioned service in place. Q4 25/26 3. Service monitoring and evaluation. Q4 25/26 	
<p>C. Ovarian Surveillance Hub for Ovarian Cancer</p>	<ol style="list-style-type: none"> 1. Launch ROCA testing pathway (non-recurrent cancer transformation funding) for patients on a waiting list for risk reducing surgery. Q1 25/26 2. Finalise modelling and business case and take through ICB governance process to ensure sustainability of the ROCA surveillance service in NCL. Q1 -2 25/26 3. Sustainably commissioned service in place. Q4 25/26 4. Service monitoring and evaluation. Q4 25/26 	

3. PERSONALISED CARE INITIATIVES	MILESTONES	CANCER ALLIANCE STRATEGIC AIM ALIGNMENT
A. Lymphoedema Service	<ol style="list-style-type: none"> 1. Single, system-wide service spec developed and embedded into provider contracts. Q1 25/26 2. Provide support to RFL Trust and Charity to develop and implement lymphoedema offer for Barnet. Q1-4 25/26 3. Work with ICB colleagues to ensure Lymphoedema is included in the community core offer. Q1-2 25/26 	SA2, SA6
B. Prehabilitation and Physical Activity	<ol style="list-style-type: none"> 1. Undertake legacy planning to mitigate risks of the specialised cancer prehabilitation/rehabilitation service not being re-commissioned. Q1-2 25/26 2. Provide commissioning support for the development, implementation and monitoring arrangements for specialist/targeted prehabilitation in line with the planned Macmillan/NIHR guidance. Q1-2 25/26 3. Provide commissioning support, where required, for the improvement of the offer of behaviour change interventions to increase physical activity throughout the cancer pathway. In particular, support for system working such as the inclusion of cancer in commissioned programmes for long-term conditions and public health. Q1-2 25/26 	SA2, SA4, SA5
C. Psychosocial Support Services	<ol style="list-style-type: none"> 1. Develop local agreements for sustainable commissioning and delivery of the Cancer Alliance integrated psychosocial pathway. Q1-2 25/26 2. In collaboration with the PCC programme, develop relevant service specifications to ensure equitable provision of levels 2-4 psychosocial support across all stages of the cancer pathway. Q1-2 25/26 3. In collaboration with the PCC programme, develop business case templates for acute and community providers. Q1-2 25/26 	SA2, SA4, SA5
D. LCS Updates (Prostate, GnRH, ? Breast)	<ol style="list-style-type: none"> 1. Review and update the current Locally Commissioned Services (LCS) specifications to ensure measurable. Q1 25/26 2. Work with ICB colleagues to identify a process for oversight and assurance that delivery of these contracts are clinically effective equitable and safe Q1-2 25/26. 3. Engage with NCL ICB colleagues to identify whether cancer LCS' can be incorporated into the NCL Long Term Conditions LCS from 26/27 onwards. Q1-4 25/26 	SA1, SA5

4. ACUTE DIAGNOSTIC AND TREATMENT INITIATIVES	MILESTONES	CANCER ALLIANCE STRATEGIC AIM ALIGNMENT
A. Breast Hormone Therapy	<ol style="list-style-type: none"> 1. Agreed patient self-admin pathway to be implemented by each provider. Q2 25/26 2. Work with LMC and other stakeholders to mitigate risk of stopping work to implement an equitable primary care delivered hormone injection pathway. Q1 25/26 	SA1, SA5
B. Breast Pain Pathway	<ol style="list-style-type: none"> 1. Document clinical pathway, service spec and clinical and operational guidelines for breast pain. Q1 25/26 2. Implement pathway at each of the NCL providers: <ol style="list-style-type: none"> a. UCHL - Live on an ad hoc basis. Working to full implementation over Q1-2 25-26 (dependent on staff training), b. RFL - Live c. NMUH - Paused. Looking at options as part of wider RFL breast service integration. d. WH - Delayed to Q2 25/26 	SA1, SA2, SA3
C. Teledermatology	<ol style="list-style-type: none"> 1. Implement pathway at each of the NCL providers. Q1 25/26 2. Achieve NHSE Deliverable of 50% referrals through USC Teledermatology Pathways. Q2 25/26 3. Implement NHSE guidance relating to USC Teledermatology tariffs ensuring services are funded to take over full BAU funding for 26/27. Q4 25/26 	SA2, SA3
D. FIT strategy 25/26	<ol style="list-style-type: none"> 1. Continue to improve the number of patients who are referred on a colorectal USC pathway with a FIT (target >80%). Q4 25/26 2. Reduce the number of patients that have a colonoscopy when there is no FIT present (target <20%). Q4 25/26 3. Continue to engage with GPs with low performance in referring patients on a colorectal USC pathway with a FIT, focusing on areas with high levels of deprivation. Q1 25/26 onwards 4. Finalise decision on FIT<10 pathway in secondary care and move safety netting for this cohort of patients to primary care. Q2 25/26 	SA1, SA3, SA4, SA6

Developing a Methodological Framework to Facilitate a Strategic Review of Fragile Cancer Services

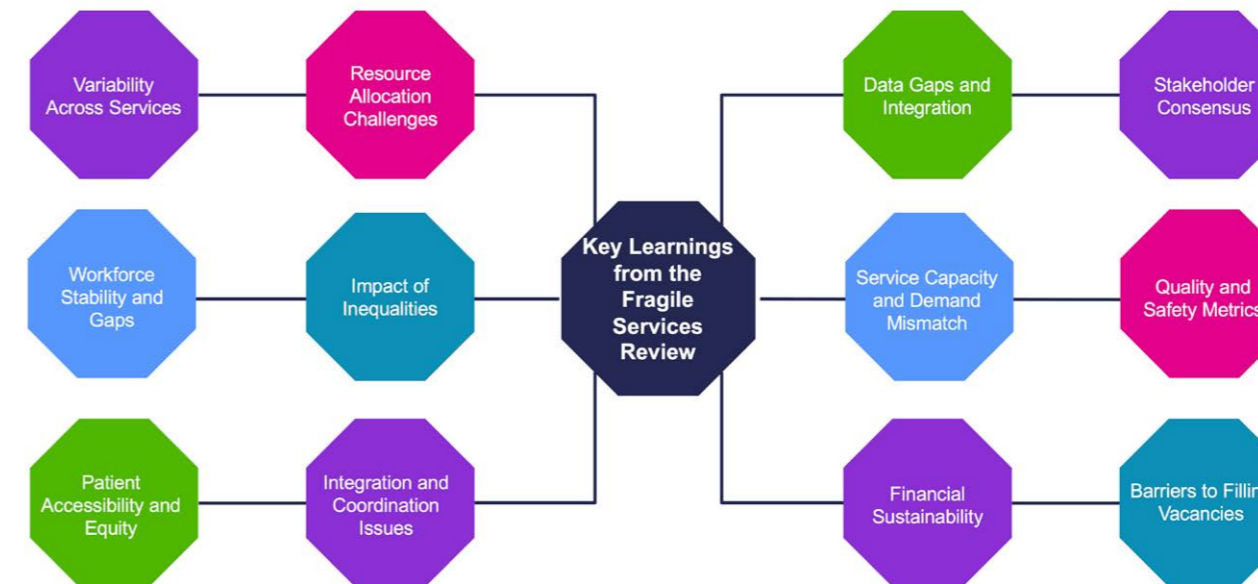
North Central London Cancer Conference 19 November 2024

Introduction and Objective

Using the framework to undertake an annual strategic review of cancer services across the cancer healthcare system aims to identify, assess and address areas of fragility within cancer services to ensure high-quality, equitable and sustainable care across NCL. By evaluating service disparities, resource gaps and patient outcomes, we strive to enhance cancer care delivery.

Methodology Overview

1. Defined fragility criteria using key indicators (e.g., patient wait times, staffing levels). Conduct a comprehensive review of best practices, National guidance and existing research.
2. Data sourced from healthcare trusts, national databases and patient outcomes. Data gaps addressed through cross-validation.
3. Workshops with clinicians, ICB and Cancer Alliance representatives. Consensus building on criteria and data interpretation.
4. Weighted criteria based on impact using multiple prioritisation frameworks. Transparent exercise undertaken to rank fragility level of services.
5. Develop actionable strategies for resource allocation, policy changes and feed these into the annual commissioning cycle and review of the cancer commissioning programme.
6. Pilot programs and ongoing evaluation using quantitative and qualitative metrics.



Outputs and Next Steps

- **Two-Tier Approach:** High-level assessment to identify areas of risk or opportunity; followed by a detailed review of concerns highlighted to inform long-term strategic changes.
- **Fragile Services Framework:** Focus on service capacity, quality and safety, workforce stability, financial sustainability, accessibility, integration, and innovation.
- **Annual Commissioning Cycle:** Framework outputs inform an ongoing commissioning cycle.
- **Stakeholder Collaboration:** Engage partners and stakeholders to identify and implement/ resource plans for risk/opportunity areas.

Conclusion

The methodological framework and an annual strategic review provides a systematic process to identify and address cancer service fragility and provide actionable insights; fostering a systemwide culture of strategic commissioning to deliver sustainable, high-performing cancer care services.

Appendix 3 - Fragile Services Framework

MEASURE CATEGORY	DETAILS	MEASURE
1. Service Capacity and Demand Analysis	Evaluate patient volume versus available resources.	1. Total number of patients served vs. outpatient appointments per month. 2. Total number of patients served vs. theatre capacity per month. 3. Total number of patients served vs. diagnostic capacity per month. 4. Analysis of average wait times for treatment per tumour per month.
	Assess staffing levels, equipment availability, and facility capacity.	1. Ratio of healthcare staff to patients per month. 2. Inventory of medical equipment. Medical equipment utilisation rate %.
2. Quality and Safety Metrics	Monitor treatment outcomes, patient satisfaction, and adherence to clinical guidelines.	1. Percentage of patients with successful treatment outcomes per month. 2. Patient satisfaction scores from outpatient friend and family test per year. 3. Compliance rate with NICE guidelines per year.
	Include measures for error rates and complication rates in treatments.	1. Incidence of treatment-related complications and errors per 1000 treatments. 2. Reporting of incidents through new PSIRF and LFPSE systems per month.
3. Financial Sustainability	Analyse cost-effectiveness of services.	1. Average cost per service by tumour type.
	Consider funding sources and financial stability of the service.	1. Percentage of budget from permanent (ICB) funding per year. 2. Percentage of budget from non-permanent funding (CA, transformation, contracts). 3. Year-over-year financial performance of cancer services.
4. Workforce Stability	Assess staff turnover rates and training levels.	1. Annual staff turnover rate per year.
	Evaluate the staff MDT effectiveness.	2. Average number of years of experience per staff member per year.
		1. Ratio of specialised to general staff in the oncology department. 2. Frequency of multidisciplinary case reviews for cancer patients. 3. Completion of staging data.

MEASURE CATEGORY	DETAILS	MEASURE
5. Patient Accessibility and Equity	Measure accessibility for different patient groups.	1. Percentage of patients treated from various demographic/ deprivation /protected characteristic groups.
	Assess service availability across geographic locations.	1. Average distance patients travel for treatment. 2. Number of outreach programs or services in underserved areas.
6. Integration and Coordination	Evaluate how well services are integrated with other healthcare services.	1. Number of integrated care pathways for cancer patients.
		2. Time from referral from primary care to first oncology appointment per month.
		3. Average diagnostic turnaround times per month.
7. Adaptability and Innovation	Assess the service's ability to adapt to changing healthcare needs and integrate new treatments and technologies.	Time to adoption of digital innovation (time from proposal, approval and implementation).
		Time to adoption of NON digital innovation (time from proposal, approval and implementation).
		Cost of decision making.
		Number of projects ongoing or completed in the last fiscal year. *No. of Pilots. *No. of adopted/BAU projects.
		Number of clinical trials conducted or participated in, in the last fiscal year.
		Number of conducted or participated in research projects in the last fiscal year.
		Number of projects conducted or participated in, the last fiscal year.

Appendix 4 - Tumour Specific ERG Cancer Fragility Risk Checklist

High Risk (H):

- **Definition:** Critical issue that could significantly impair the ability to provide cancer services, meet patient needs, or lead to serious consequences if not addressed immediately.

• **Indicators:**

- Large mismatch between demand and capacity (e.g., clinics or theatre consistently overwhelmed).
- Significant staff shortages or high turnover, impacting care delivery.
- Below-benchmark patient outcomes (survival, satisfaction, etc.).
- Prolonged delays in diagnosis or treatment, beyond safe clinical windows.
- Severe accessibility issues, causing major disparities or extremely long wait times.

Medium Risk (M):

- **Definition:** Concerning issue that could escalate if left unresolved but is manageable in the short term. Mitigation actions should be taken to prevent it from becoming a high risk.

• **Indicators:**

- Occasional mismatch between demand and capacity but manageable with current resources.
- Moderate staff shortages or turnover, with some impact on service delivery.
- Patient outcomes slightly below benchmarks but not critically low.
- Delays in diagnosis or treatment, but within reasonable limits.
- Noticeable accessibility issues, with moderate impact on patient care.

Low Risk (L):

- **Definition:** Minor issue that has minimal impact on operations or patient care. It requires monitoring but does not pose immediate danger to service delivery.

• **Indicators:**

- Slight or occasional strain on capacity but not affecting patient care.
- Minor staffing issues with no significant impact on service delivery.
- Patient outcomes and satisfaction at or near benchmarks.
- Delays in services are rare or within clinically acceptable limits.
- Accessibility issues have minimal or no impact on patients' ability to receive care.

Measure Category	Criteria	Risk Identified	Risk Description	Level of Risk H/M/L
Service Capacity and Demand Analysis	Is there a mismatch between patient volume and outpatient clinic capacity?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Are resources for diagnostics (e.g., imaging, pathology) meeting the demand?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Are theatre capacities sufficient to handle the caseload?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Staffing and Resources	Is there a shortage of clinical staff (doctors, nurses, etc.) for current patient volume?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Is there a lack of non-clinical support (administrative, technical staff)?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Are staff turnover or absenteeism rates impacting service delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Patient Outcomes	Are survival or recovery rates below benchmarks for this cancer type?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Are re-admission rates higher than expected?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Is patient satisfaction with care below acceptable levels?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Service Efficiency	Are there delays between referral and diagnosis for patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Is the treatment initiation delayed beyond clinically recommended timeframes?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Are resources for completing treatment plans (e.g., chemotherapy, radiotherapy) insufficient?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Accessibility	Are there geographic disparities in accessing outpatient care?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Is access to advanced treatment modalities (e.g., precision medicine, radiotherapy) limited?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Are waiting times for specialist appointments beyond recommended limits?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

OVERALL Criteria

High

- 3 or more “High Risk” ratings across domains or any critical issue within key domains such as service capacity or patient outcomes, leading to an inability to meet demand, unacceptable delays in treatment, or patient harm.

Medium

- 2 or more “Medium Risk” ratings across domains, or a combination of “High” and “Low Risk” ratings, where the overall situation presents significant vulnerability without imminent failure.

Low

- No more than 1 “Medium Risk” rating across domains and the majority of criteria are rated as “Low Risk.”

1. Commissioning Tools

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Effective commissioning is supported by a range of practical tools, frameworks and performance measures that ensure high-quality service delivery. These include:

- Service Specifications and Clinical and Operational Guidelines**
 Comprehensive frameworks outlining service expectations, clinical and operational requirements and outcome measures to maintain high standards of cancer care.
- Business Cases**
 Strategic proposals guiding commissioning decisions, covering:
 - Standardising Services – Ensuring equitable access to cancer services, treatments, and outcomes.
 - New Services and Service Transformation – Addressing unmet needs and improving patient care pathways.
 - Business as Usual (BAU) – Transitioning pilot programmes (often funded through cancer transformation initiatives) into permanent services and sustaining existing service levels.
 - Introducing Innovations – Incorporating new technologies and medical advancements into current service models.

2. Templates and Resources

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A collection of key resources to support commissioning processes:

- Data Directory – A central repository of essential cancer datasets for informed commissioning decisions.
- Project Initiation Document (PID) Template – A structured template to define project objectives, scope, and Implementation Plans.
- Impact Assessment Templates and Examples – Tools to evaluate the potential effects of commissioning decisions.
- Operational Guidelines – Best practice recommendations for service implementation and management.
- Briefing Paper Template – A standard format for summarising key information for stakeholders.
- Fragile Services Framework – A structured approach to identifying and managing vulnerable cancer services at risk of instability.
- Stakeholder Mapping Tool – A framework for identifying and engaging key stakeholders in commissioning processes.
- Black Book – A directory of key stakeholders and organisations interested in partnership working.
- Communications Plan Template – A structured guide for effective stakeholder engagement and information sharing.

Acknowledgment

This document is the result of extensive collaboration, research and engagement, to clarify the purpose and responsibilities of commissioning and sets out the process for commissioning cancer services in North Central London.

The development of the “NCL Fragile Service Framework” has been truly collaborative, shaped through one-to-one discussions, multidisciplinary workshops and detailed stakeholder consultations.

The “Cancer Commissioning” and “Fragile Services” frameworks combined provide a rigorous methodology, and in combination with real-world data, risk assessment and stakeholder perspectives will ensure that commissioning decisions are not only evidence-based but also patient-centred and sustainable.

We would like to extend our sincere thanks to all the clinicians, patients and wider stakeholders who contributed their expertise, time and insights.

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North Central London
Health and Care
Integrated Care System

